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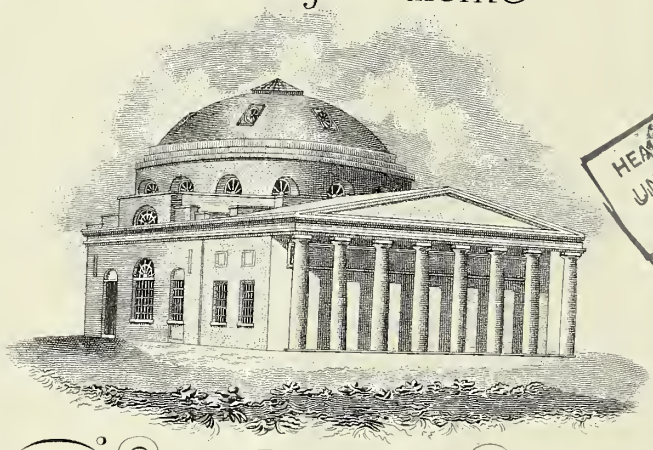

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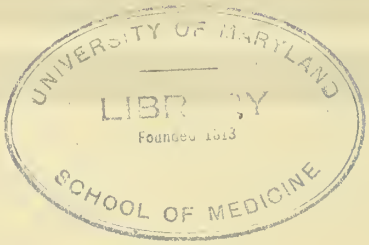


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# THE JOURNAL
OF THE
# Indiana State Medical Association

OLUME 38
MBER 1

INDIANAPOLIS, JANUARY, 1945

Per Year, $3.50
Single Copy, 50 Cents

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## SECRETARIES' CONFERENCE

January 21, 1945

Interesting program—see page 17. Everyone invited.

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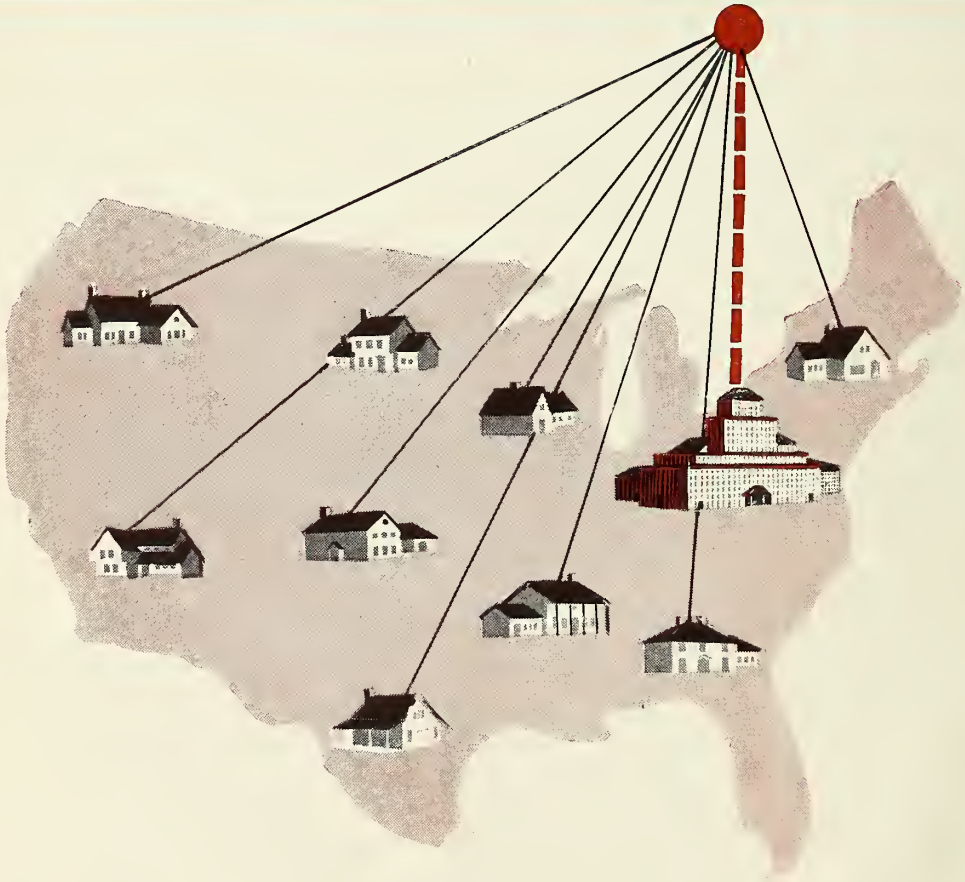
# 9 out of 10 cases of EPILEPSY are treated in the home



# THE JOURNAL

OF THE

# INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

*ISSUED MONTHLY under Direction of the Council*

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 38 JANUARY, 1945 Number 1


## RADICAL VERSUS CONSERVATIVE TREATMENT FOR GYNECOLOGIC CONDITIONS*


VIRGIL S. COUNSELLER, M.D.†

ROCHESTER, MINNESOTA


The organs that compose the female generative tract—that is, the vagina, uterus, fallopian tubes and ovaries—may be affected independently by disease or trauma, or disease of one may seriously affect another. The physiologic importance of the ovaries is emphasized by the fact that ovarian activity is in some manner connected with the functions of the pituitary and thyroid glands. The ovaries control the action of the endometrium through the various phases of the menstrual cycle. When both ovaries are removed, complete atrophy of the endometrium results. The atrophy that occurs after the menopause, whether it is physiologic or the result of radiation, is not as profound as that after castration. Also, I have never seen carcinoma of the corpus uteri develop after bilateral surgical castration, but it does develop after both the normal and the radiation menopause. This indicates that some ovarian function continues even after the menopause, and that consequently these organs should not be removed during abdominal hysterectomy without a valid reason. A great difference of opinion exists among the members of the medical profession concerning this point, but I firmly believe that the ovaries have a function or functions, other than reproduction, which do not cease at menopause. The general tendency for a woman to become obese after castration may be related to metabolism.

The indications for radical surgical treatment, therefore, should be definite. If the observations on examination suggest the possible necessity of extirpation of all pelvic organs, this matter should be discussed thoroughly with the patient in order to clarify the reasons for the procedure and the possible consequences. All physicians must agree, speaking generally, that many surgical procedures on the pelvic organs may not be absolutely necessary and that the anticipated results are not clearly understood by the surgeon. Some women attribute many functional complaints to the pelvic organs and insist on operation. Eventually these women find a surgeon who will oblige them, since it is well known that even in complicated pelvic conditions the mortality rate is low. The extreme example of needless surgical procedures is the case in which after multiple operations on the pelvic organs, panhysterectomy finally is performed, without benefit. In order to determine whether surgical treatment is indicated, it might be necessary to examine the patient under anesthesia so that the uterus and adnexa can be palpated separately, especially for size, irregularity and mobility. A uterus that is of normal size and that easily can be replaced rarely requires surgical correction.

Uterine fibroid, which is the commonest gynecologic lesion seen in the surgical pathology laboratory, may or may not require surgical or radiation treatment. The presence of one or more such lesions alone does not indicate the necessity of operation. However, if the tumor is producing disturbances in menstruation or pressure, is increasing in size, or is undergoing some degeneration as evidenced by pain and fever, operation should be undertaken. The risk is not excessive.

Myomectomy, which is a conservative surgical procedure, is indicated in women less than thirty-five years of age only if it is applicable. If the myometrium is filled with seedlings as well as multiple larger fibroids, hysterectomy rather than myomectomy should be performed. Incidentally, hysterectomy is an easier operation to perform and produces more satisfactory results than myomec-


* Read at the General Meeting of the Indiana State Medical Association, at Indianapolis, on October 3, 1944.



† From the Division of Surgery, Mayo Clinic, Rochester, Minnesota.

tomy. However, removal of the uterus for fibroids is not an indication for castration. In cases in which the women are less than forty years of age, there is recurrence of multiple fibroids after myomectomy in 20 per cent of the cases. The recurrence rate in cases in which the women are more than forty years of age is 10 per cent or less, depending on whether the fibroids were single or multiple. In cases in which removal of the uterus is indicated, abdominal hysterectomy is the operation of choice, especially in the multiparous patient who has a diseased cervix. If the woman has not borne children and no separation of the pelvic fascia or congenital defects in the fascial attachments are apparent, subtotal hysterectomy may be sufficient. A patient who has a normal-sized uterus and who has menorrhagia and metrorrhagia caused by a small submucous fibroid should not be treated conservatively with estrogen and iron over a long period. Abdominal myomectomy alone or vaginal hysterectomy and myomectomy definitely is indicated in the childbearing period. Fibroids rarely become malignant but may be associated with carcinoma of the corpus uteri, especially if a sanguineous watery discharge has been present for a long time. In such conditions panhysterectomy should be performed.

Conservative treatment has greater application in inflammatory disease than in any other pelvic condition. The use of sulfa drugs and penicillin, especially in the treatment of gonorrhea, alters the course of this disease tremendously. In acute cases subcutaneous administration of 60,000 units of penicillin usually eradicates all traces of infection. Consequently, the complicating sequelae that formerly required surgical treatment are avoided. Some patients who have chronic gonorrheal infection also respond to this treatment. In addition, conservative measures, such as the use of heat and diathermy, should be recommended. A sequela, however, such as a fixed retroverted uterus or hydrosalpinx with fixed adnexa which interferes with normal function may require conservative surgical measures rather than complete hysterectomy.

Conservative management of postabortal infection is not as satisfactory as of gonorrheal infection, since the response to sulfa compounds and penicillin is less remarkable. Early use, however, of these preparations is important, since it may avert rapidly-developing peritonitis and death. Most of these patients eventually require surgical treatment. The most dangerous sequela of postabortal infection is tubo-ovarian abscess with a clean peritoneum. If the presence of such an abscess can be definitely established, it should be drained through the cul-de-sac, and weeks later the adnexa should be removed by laparotomy. The abdominal approach to such an abscess is inadvisable because of the probability of rupture and resulting virulent peritonitis. This condition is manifested by severe pain and rigidity of the abdomen during the immediate postoperative period. The picture is identical to that noted eight or ten days after rupture of an anastomosis of the large intestine; that is, the blood pressure drops dangerously, the patient appears to be in profound shock, and the outcome is usually fatal in a few hours.

A small percentage of patients who have chronic inflammatory disease of the pelvis require radical surgical treatment; that is, panhysterectomy. The advantageous time for conservative treatment has long since passed and panhysterectomy is indicated even in the childbearing period. The necessity of this procedure must be explained to the patient or the responsible relative. In these cases the uterus and both adnexa are one solid mass without evidence of inflammation. The cecum and appendix or sigmoid colon may be so firmly attached to the generative organs that mobilization of the latter requires great care to prevent the formation of a fecal fistula.

The ovary is a common site of cysts and tumors of all types, but a cystic ovary, especially in a woman less than thirty-five years of age, rarely requires operation. These cysts usually are of simple type and come and go spontaneously. Often cure occurs after rupture during bimanual examination. A malignant cyst in a young woman is rare. On examination a dermoid cyst usually can be differentiated from a simple cyst; although the former is a surgical lesion, it is not of an emergency nature. Conservative treatment has no place in the management of ovarian cysts in patients more than forty years of age, since the incidence of malignancy increases with age. As far as I know, differentiation of a malignant ovarian cyst from a simple cyst by physical examination is impossible. Intracystic malignancy spreads by perforation, and not by lymphatic channels, until the omentum is involved. Unnecessary delay in surgical exploration may result in death. Simple ovarian cysts in cases in which the women are more than forty years of age, in contradistinction to cases in which the patients are younger, rarely disappear spontaneously. Twisted ovarian cysts, regardless of the age of the patient, are a surgical problem. In cases in which a benign pelvic condition exists, removal of adnexa is easier than a conservative operation, but the latter is more desirable and beneficial.

Among pelvic conditions, conservative treatment has its second greatest application in cases of the endometrial lesions, since it afflicts mostly young women. Endometriosis also ranks second in frequency among gynecologic lesions encountered in the surgical pathology laboratory. The fact that it is encountered in association with other surgical lesions accounts in part for its high incidence. This lesion may occur in the second decade of life, but it is more common in the third and fourth decades. The patient's complaint may be sterility or painful menses. Among patients who have endometriosis the incidence of sterility is 34 per cent. Pregnancy rarely occurs more than once. During pregnancy the disease is quiescent, and after delivery activity seems to become more pronounced.

Pain, which is an extremely variable factor, depends to a great extent on the location of endometriosis. If the lesions are in the myometrium, the uterosacral ligaments or the rectovaginal septum, the pain is activated during menstruation and is severe. The tissue of which these lesions are composed is the same as the endometrium, histologically, and depends for stimulation on ovarian function. For this reason endometriosis becomes quiescent after surgical castration or after the menopause, which may be either normal or produced by radiation.

Some patients are more sensitive than others to pain in the pelvis and therefore correct evaluation of the amount of disability is sometimes difficult. For this and many other reasons the question of whether conservative or radical surgical treatment should be undertaken for endometriosis is difficult to answer. I doubt whether conservative surgical procedures materially improve the chances for pregnancy, and seriously question whether they should be undertaken with that possibility in mind. Approximately the same small number of women eventually will become pregnant without operation. As a matter of fact, surgical intervention may actually destroy any possibility of pregnancy. A conservative surgical procedure for the sole purpose of relief of pain is only slightly more justifiable than for increasing the possibility of pregnancy. The incidence of recurrence of pain within three years is so large that the procedure certainly is of questionable value. The occasional patient who receives prolonged relief from a conservative surgical measure may encourage the surgeon to operate more frequently, but he should constantly keep in mind the rarity of good results. Another important factor is that many of these patients have an early menopause with resulting cessation or gradual diminution in intensity of symptoms.

Radical surgical treatment is indicated when the pelvis is filled with painful nodular masses, and the ovaries are replaced by huge chocolate cysts. Pregnancy is certainly impossible, ovarian function is greatly reduced, and the patient is uncomfortable most of the time. Panhysterectomy is the operation of choice. If the ovarian tissue is removed with the uterus, some lesions on the sigmoid or lateral walls of the pelvis may be left there since they become inactive. Unfortunately, this situation may occur in young women, but the indications are the same. In my opinion, young women should be told the nature of the disease and encouraged to endure the discomfort until they are at least thirty-five years of age. If at this age the condition remains unchanged, radical surgical measures are justified. Intra-uterine radium or roentgen therapy is inadvisable since these masses subsequently may undergo degeneration and produce fever. Also, ovarian activity in young women tends to return after treatment by irradiation. The uterus begins to discharge small amounts of blood irregularly, and the discomfort returns.

The uterus occasionally contains multiple adenomyomas, but few lesions are present elsewhere. In such instances total hysterectomy with preservation of the ovaries produces good results.

Certain surgical procedures that usually are classified as radical may be considered conservative under some conditions. Vaginal hysterectomy is one of them. A patient in the late thirties or early forties who has severe menorrhagia or metrorrhagia is a difficult problem to the physician in general practice and often even to the specialist. I refer to the case in which the pelvic organs appear on physical examination to be normal and in which the cause of bleeding is indefinite. If the bleeding fails to respond to medical treatment after a reasonable time, vaginal hysterectomy with preservation of the ovaries is the procedure of choice. Many physicians prefer to give a menopausal dose of radium, but the production of an artificial menopause seems unwise. Vaginal hysterectomy is easy to perform and carries a low mortality.

Cystocele or rectocele and a lacerated perineum, although the condition may be causing no symptoms, can be repaired at the time of vaginal hysterectomy. The patient may continue in excellent health for several years without menopausal symptoms. I recently examined a patient forty-three years of age, who had undergone a vaginal hysterectomy for uncontrolled uterine bleeding at the age of twenty-one years. She complained of dyspareunia, which was caused by a small endometrioma in the vaginal vault. The vault was opened and the endometrioma was excised. The ovaries were entirely normal, and there was no evidence of ovarian failure. I am convinced that the interests of the patient are better served by vaginal hysterectomy and repair than by radiation therapy or by a combination of plastic repair of the vagina and abdominal hysterectomy.

In a discussion of plastic operations for cystocele, rectocele and prolapse, the indications should be clearly defined. Young patients frequently are encountered who have had plastic repair of the vagina with laparotomy for removal of one ovary, the appendix, and uterine suspension. The usual symptoms for which operation is undertaken are exhaustion, backache, and inability to become rested. Obviously, relaxation of the vaginal outlet and the position of the uterus have little to do with these symptoms. Cystocele becomes troublesome when the bladder is infected or cannot be completely emptied. Inability to empty the rectum because of a large rectocele is a similar problem. Various degrees of prolapse also may cause no symptoms, and evaluation of the amount of pelvic discomfort that results from relaxation of the outlet presents a real diagnostic problem. Therefore, in my opinion, physicians should be ultraconservative in advising a plastic operation on the vagina or a combination of this operaton with laparotomy during the childbearing period. Operations of

permanency are usually more satisfactory and are reserved for a later period in life.

In conclusion, I would like to stress the importance of accurate diagnosis in gynecologic conditions, especially in the young patient. The indications for treatment, either radical or conservative, are usually definite and depend on a careful analysis of each case.

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# THE EVALUATION OF PENICILLIN IN OCULAR THERAPEUTICS*†

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Since the author's last report in which a review was made of forty-one cases of ocular infection treated with penicillin, eighteen new cases have been added which further confirm the conclusions previously drawn. It is now generally known that penicillin has a marked bacteriostatic effect on the staphylococcus, which is ordinarily only slightly affected by the sulfonamide drugs, and that organisms that are sulfonamide-resistant, or fast, are frequently extremely sensitive to it. Theoretically, penicillin is superior to sulfonamides not only in that it is more potent, but also in that secretion and autolytic products, both of which are usually present in cases of external ocular infections, do not inhibit its bacteriostatic action. Furthermore, unlike sulfonamides, penicillin does not have an adverse effect on the regeneration of the corneal epithelium. All in all, these attributes make the drug of special interest to the ophthalmologist.

### Absorption, Penetration and Distribution of Penicillin

When penicillin is injected intravenously in large amounts, the drug reaches the eyeball within fifteen minutes.[1] The penicillin concentrations attained in the various ocular tissues and fluids in descending order are: extra-ocular muscles, conjunctiva, sclera, chorioretinal tissues and aqueous humor. Only a trace is found in the cornea and vitreous, and none in the crystalline lens.

Penicillin, because of its great penetrability, when applied locally, even in small amounts, produces a much higher concentration in the conjunctiva, sclera, iris and aqueous humor than when it is administered intravenously, even in massive doses. However, the amount of penicillin reaching the tissues of the posterior segment by the local route appears inadequate for the proper treatment of infections in that region; therefore, if penicillin is indicated in an infection of the posterior segment it must be given parenterally.

### Administration of Penicillin

Before undertaking active penicillin therapy in case of ocular infection, it is important that the physician identify quickly and accurately the responsible organism or organisms. Then by means of titration tests the sensitivity or non-sensitivity of the organism to penicillin is determined. For example, if a certain strain of staphylococcus is not affected by penicillin when in direct contact with it in a test tube, it is obvious that the drug would be valueless if administered to the patient. Thus loss of time and material is avoided.

It has already been stated that penicillin can be administered either parenterally or locally. However, in view of the fact that the most promising results are obtained in external ocular conditions treated by local application, and that the large amounts of penicillin needed for parenteral administration are not likely to be available in the immediate future, emphasis is placed upon the local therapy. Penicillin is administered locally either in the form of drops, corneal baths, or ointment. Subconjunctival injections are not indicated as the concentrations attained in the external ocular tissues by this route are not any higher than if the drug were applied topically.[1]

The recommended concentration of penicillin in the solution or ointment ranges from 250 to 2,500 units per cc. or gram. Since the optimum dosage of penicillin has not been determined, and since penicillin causes little or no irritation when applied in much higher concentration, it is probably better to err on the side of too great a concentration rather than too small. Because of dilution with tears, rapid diffusibility and escape through obvious channels, penicillin drops must be applied hourly if a uniform and adequate concentration is to be achieved.

In severe infections, as in hypopyon ulcer, penicillin is best applied in the form of a corneal bath. For this purpose a Barkan's plastic lens or eye

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* Presented before the Section on Ophthalmology and Otolaryngology, of the Indiana State Medical Association, at Indianapolis, October 4, 1944.

† Indebtedness is expressed to Colonel H. L. Conner for his help in this investigation.

[1] Struble, G. C., and Bellows, J. G.: Studies on the Distribution of Penicillin in the Eye and Its Clinical Application, *J.A.M.A.*, **125**:685, 1944.

contact cup suggested by Struble and Bellows is satisfactory. The simplest and most economical method of achieving a suitable penicillin concentration in the anterior segment of the globe is by means of an ointment. For direct applications of penicillin to the globe, a variation of the simple ointment (U.S.P.) base was found to be superior to oil in water emulsion, vanishing type stearate or lubricating jelly. In treating the lid margins and skin of the lids where slight epithelial damage is relatively unimportant, the vanishing type of stearate base is preferable.

### Toxic Reactions

Toxic reactions are uncommon and follow either the parenteral or the local administration of penicillin. In five hundred cases in which the drug was administered parenterally, the untoward effects observed by Keefer and his associates[2] were fever, or chills and fever in seventeen cases; thrombophlebitis in nineteen; urticaria in fourteen; tenderness at site of injection in five; headaches and flushing of the face in ten; tingling in the testes in two; and pains in the muscles in two. Following the local applications the adverse effects may be due to some impurity causing an acute inflammatory reaction or to hypersensitization to penicillin itself.

In the latter instance, swelling and reddening of the skin of the lids becomes evident after several days or weeks of treatment. These symptoms are frequently associated with pruritis. The patch test is often positive. Upon cessation of penicillin therapy the swelling subsides and is succeeded by wrinkling and scaliness of the skin.

### Clinical Application

*Blepharitis:* Staphylococcus is the organism that most commonly causes blepharitis. Previous forms of therapy, including sulfonamides, have left much to be desired. The bacteriostatic effect of penicillin against the staphlococcus is far greater than that of any other known substance. It is reasonable, therefore, to assume that this drug will prove to be an effective agent in combatting blepharitis. Evidence is now being accumulated which proves that this hope is not unfounded. Florey and Florey[3] report that from a series of forty-six cases cure was obtained in thirty-seven; while Bellows obtained complete recovery in only five out of eleven.

*Gonorrheal Ophthalmia:* Although sulfonamide therapy in gonorrheal conjunctivitis was a distinct advance over the old forms, it seems likely now that even these excellent results will be excelled by penicillin. In the case reported by Florey and Florey, the infection persisted despite three and one-half weeks of sulfapyridine therapy. Twelve hours after the institution of local penicillin therapy a marked improvement was noted, and within forty-eight hours the purulent secretion had ceased entirely. The clinical response to the parenteral administration of penicillin in Griffey's case[4] was also prompt, for within ten hours the exudate had diminished greatly, while in the case reported by the author twenty-four hours of local and parenteral penicillin therapy produced negative smears and a marked clinical improvement.

*Ophthalmia Neonatorum:* Sievers, et al.,[5] reported treating eight cases of ophthalmia neonatorum with penicillin, five of which were definitely caused by the gonococcus. In two of the other cases gram-negative intracellular diplococci, giving positive oxidase reactions when grown on chocolate agar, were found. The causative agent was not determined in the eighth case. After the intravenous administration of 60,000 to 330,000 units of penicillin smears and cultures became negative in nine to twenty-four hours, clinical improvement was noted in one day and recovery was completed in three to six days.

*Acute Staphlococcic Conjunctivitis:* Not only conjunctivitis caused by the gonococcus but also those due to some other forms of bacteria respond rapidly to penicillin therapy. Thus, in twelve cases of acute staphylococcic conjunctivitis reported by Florey and Florey cure occurred in one to five weeks. In fourteen similar cases Bellows, using a higher concentration of the drug, obtained complete recovery in eleven within one to three days. In one person the first eye returned to a normal state in three days, and the second in ten days.

*Chronic Staphylococcic Conjunctivitis:* Penicillin therapy produced marked improvement or complete recovery in cases of chronic staphylococcic infections which had resisted other forms of therapy from two months to fifteen years. In the one unresponsive case of the eleven reported by Bellows, the failure could be attributed to the associated keratoconjunctivitis sicca (see Table I).

**TABLE I**

**PENICILLIN THERAPY IN CHRONIC STAPHYLOCOCCIC CONJUNCTIVITIS**

| *Author* | *Number of Cases* | *Organisms* | *Recovery and Time Required* | *Failures* |
|---|---|---|---|---|
| Florey & Florey | 14 | In 11 cases, pure colonies. In 3 cases, mixed infections. | 14 recoveries 1 to 5 weeks | 0 |
| Bellows | 11 | Hemolytic and non-hemolytic Staphylococcus | 6 recoveries 2 days to 3 weeks | 1 |

*Acute Streptococcic Conjunctivitis:* In view of marked inhibitory effect of penicillin against the streptococcus in vitro experiments, and the great protection for mice against tremendous lethal doses

[2] Keefer, C. S.; Blake, F. G.; Marshall, E. K., Jr.; Lockwood, J. S., and Wood, W. B., Jr.: Penicillin in the Treatment of Infections: A Report of 500 Cases, *J.A.M.A.*, **122**:1217, 1943.

[3] Florey, M. C., and Florey, H. W.: General and Local Administration of Penicillin, *Lancet*, **1**:387, 1943.

[4] Griffey, W. P.: Penicillin In Treatment of Gonorrheal Conjunctivitis, *Arch. Ophth.*, **31**:162, 1944.

[5] Sievers, J. J.; Knott, L. W., and Soloway, H. M.: Penicillin in the Treatment of Ophthalmia Neonatorum, *J.A.M.A.*, **125**:690, 1944.

**TABLE II**

**PENICILLIN THERAPY IN ACUTE STREPTOCOCCUS CONJUNCTIVITIS***

| *Number of Cases* | *Organisms* | *Remarks* |
|---|---|---|
| 1 | Streptococcus in short chains. | Secretion ceased in 24 hours. Culture and Smears negative in 48 hours. |
| 2 | Pure culture of Streptococcus viridans. | Right eye cured in 48 hours. Left eye cured in 36 hours. |
| 3 | Hemolytic Streptococcus. | Corneal ulcer and conjunctivitis cured in six days. |

* (Taken from Bellows.)

of hemolytic streptococcus, it is not surprising that acute conjunctivitis caused by the streptococcus should respond rapidly to this drug (see Table II).

*Koch-Weeks Conjunctivitis:* Only one case of Koch-Weeks conjunctivitis was encountered. Staphylococcus albus was also present. The conjunctiva returned to a normal appearance within forty-eight hours of penicillin treatment.

*Conjunctivitis with Inclusion Bodies:* A soldier entered the hospital with a history of having had red eyes and slight secretion for more than five months. Two days before entering the hospital the eyes became acutely inflamed and the secretion increased. Bacteriological studies disclosed inclusion bodies and many non-hemolytic Staphylococcus albus. Penicillin in the form of drops instilled hourly was prescribed, and within forty-eight hours the acute manifestations were absent but the conjunctiva still showed a velvety hypertrophy. After two weeks of therapy there was a definite improvement. Unfortunately, circumstances arose which prevented further observation of this person.

*Penicillin Therapy in Corneal Ulcers:* Corneal ulcers produced by penicillin-sensitive organisms respond rapidly to penicillin therapy. Thus, in a total of ten cases reported,[3] recovery occurred in eight cases within from twelve hours to seven days, depending upon the severity and duration of the infection. In the two cases that did not respond within seven days, one was hypopyon ulcer in an eighty-year-old woman, which cleared entirely in one month, while in the other, a ring ulcer, penicillin therapy was terminated because the B. coli was the causative agent.

*Penicillin Therapy in Dacryocystitis:* Penicillin invariably made the discharge from the lacrimal sac sterile in six cases of dacryocystitis reported by Florey and Florey, and in the single case reported by Bellows. However, actual clinical recovery occurred in only three cases.

*Penicillin Therapy in Episcleritis:* Three cases of episcleritis were treated with penicillin. In two, recovery occurred in one to seven days, respectively. A third that had been treated for several weeks by the older methods, without any appreciable change, showed improvement within one day of penicillin therapy, and complete recovery in seven days. Recently three additional patients suffering from episcleritis responded favorably and rapidly to penicillin.

*Penicillin Therapy in Chronic Uveitis:* In six cases of uveitis, 300,000 units of penicillin administered parenterally within a period of sixty hours produced no appreciable improvement—see Table III. (Since this article was submitted for publication, four more patients with chronic uveitis and one patient with sympathetic ophthalmia received penicillin therapy. In not one single instance was improvement noted during the treatment.)

**TABLE III**

**PENICILLIN IN UVEAL DISEASE**

| | *Diagnosis* | *Amount of Penicillin in Units* | *Result* |
|---|---|---|---|
| Case 1* | Chronic Exudative Choroiditis | 200,000 | No improvement |
| Case 2* | Chronic Exudative Choroiditis | 200,000 | No improvement |
| Case 3* | Bilateral Iridocyclitis | 200,000 plus penicillin eye drops | No improvement |
| Case 4 | Chronic Iridocyclitis | 300,000 | No improvement |
| Case 5 | Chronic Exudative Choroiditis | 300,000 | No improvement |
| Case 6 | Chronic Exudative Choroiditis | 300,000 | No improvement |

* (Data from Struble, G. C., and Bellows, J. G.)

**Comment**

Promising results have been obtained from the application of penicillin therapy in the treatment of blepharitis. Complete recovery occurred in 80 per cent of the cases reported by Florey and Florey, and in 45 per cent of a smaller series reported by Bellows.

Penicillin therapy seemingly is effective in staphylococcic conjunctivitis. This efficacy is particularly noticeable in chronic staphylococcic infections of the conjunctiva which have resisted other forms of therapy for months or even years, while the use of penicillin in such instances brings about complete recovery in a few days or weeks. In those cases where no response to penicillin therapy was observed, the reason for this could be explained upon some complicating factor or factors, such as the presence of keratoconjunctivitis sicca, acne rosacea and hypersensitization to penicillin.

Penicillin is of limited value in the treatment of dacryocystitis because it has little influence upon the stenosis itself; however, it does make the secretion sterile.

Only a few cases of gonococcal conjunctivitis have been treated with penicillin. The results obtained were the most rapid recoveries ever recorded for this disease, thus indicating that this drug will become the most useful agent in combatting this infection.

Seemingly penicillin is also a potent agent against infections of the conjunctiva caused by the

Koch-Weeks organism and the streptococcus. Further, in one case of conjunctivitis, in which intracellular and extracellular inclusion bodies were observed, a gradual improvement was noted in the chronic symptoms within two weeks. The cause of the infection with inclusion bodies was undetermined, there being no trachomatous signs, such as cicatricial formation or pannus, nor any exposure in a swimming pool.

Corneal ulcers caused by penicillin-sensitive organisms respond promptly to treatment. In a rapidly-progressing ulcer, penicillin in the form of corneal baths is indicated.

Although the etiological factors usually considered in episcleritis, gouty diathesis, allergy, focal infection, tubercle bacillus, or syphilis are such that preclude the use of penicillin; in six cases, however, in which the drug was used, improvement seemed to follow its use.

Penicillin also seemed effective in a few cases of acute and chronic conjunctivitis in which smears and cultures were negative. In general, however, where smears and cultures were negative, or where the organisms isolated from the conjunctiva belonged to those groups known to be unaffected by the drug, penicillin therapy failed.

In conditions where tests to determine the bacteriologic factors are difficult or impossible to carry out, such as in the inflammatory diseases of the uvea, penicillin has been ineffective. There were eleven such cases belonging to this group; seven persons with chronic exudative choroiditis, and three with chronic iridocyclitis and one with sympathetic ophthalmia. In none of these cases did penicillin seem to influence the course of the disease. What the drug will accomplish in acute iridocyclitis and choroiditis has not yet been determined.

### Summary and Conclusion

Previous conclusions made by the author are confirmed in this report, namely, that the local application of penicillin, either in the form of drops, corneal baths, or ointment, is a very satisfactory form of treatment for external ocular diseases caused by organisms known to be sensitive to penicillin. Among the conditions that have been treated successfully with penicillin are acute and chronic infections of the lids, conjunctiva, and cornea, caused by staphylococcus, streptococcus, gonococcus and pneumococcus. In deep intra-ocular infections, where the causative agent is difficult to determine, such as iridocyclitis or choroiditis, penicillin has been ineffective.

It is hoped that as penicillin becomes readily available more extensive clinical investigations will throw further light in establishing the therapeutic principles of penicillin therapy in ophthalmology.

## DISCUSSION

Lieutenant Colonel Gilbert C. Struble, Fort Benjamin Harrison, Indiana: Major Bellows has covered the subject so well that there is little else I can offer. I am in agreement with his results, particularly in acute conjunctivitis and posterior uveitis. It is probable, on the other hand, that conjunctivitis caused by the Morax-Axenfeld and the Koch-Weeks organisms will not respond favorably to penicillin eye drops, because these organisms are of the gram-negative influenza classification, which are known to be penicillin resistant. Further observations are indicated before this question can be definitely settled. Probably some of the greatest indications for penicillin therapy are the conditions of orbital cellulitis, erysipelas, cavernous sinus thrombosis, and early endophthalmitis and panophthalmitis of endogenous and ectogenous origin. These conditions call for penicillin by parenteral injection, and in those cases associated with penetrating injuries of the anterior segment, by local penicillin instillation as eye drops as well.

In general, regarding dosages, it may be said that this is being revised up instead of down. The use of inadequate doses tends to cause chronicity and penicillin-resistant strains of bacteria. Temporizing with inadequate dosages, when the sight of an eye or a life is at stake, is not justifiable. We recommend that in such severe cases 300,000 units of penicillin be dissolved in 1,000 cc. or more of normal saline (depending on the patient's fluid requirements), and administered by constant, slow, intravenous drip each twenty-four-hour period, until definite improvement is noted. This should be followed by 200,000 units and later 100,000 units in normal saline by intramuscular injection, divided into eight equal doses, given at three-hour intervals. In our experience, the more concentrated solutions, that is, 1 cc. containing 10,000 units of penicillin dissolved in normal saline instead of distilled water, adds much to the patient's comfort. We have seen one case of erysipelas recur following the administration of 780,000 units of penicillin over a three-day period. This case subsequently required another 485,000 units, plus surgical drainage of a cervical abscess for cure. We also feel that penicillin solutions used locally as eye drops and as corneal baths with a contact cup are of very great value in the treatment of corneal ulcers. It must be emphasized, however, that the other usually accepted methods of therapy, namely, atropine, heat, fever therapy, et cetera, are still necessary for cure of severe cases. Kirby has shown that solutions of penicillin in normal saline retain their full potency at room temperatures for seven days, with only slight deterioration thereafter, and that most lots of penicillin in normal saline retain their full potency at room temperature for ten to twelve days. It is therefore practical to make up and dispense these solutions to the patient, with instructions to use two or three drops as directed.

We have found the U.S.P. ointment to be too stiff to be practical for use as an eye ointment.

The following variation of the U.S.P. base has been satisfactory in our hands:

Wool fat 10 gms.

Petrolatum 30 gms.

Penicillin 100,000 units in distilled water 1 cc.

This makes up 40 cc. of ointment, one gram of which contains 2,500 units. It can be placed in and dispensed from any ordinary syringe, and is non-irritating to the eyes. In especially hot climates the wool-fat content can be cut and white wax added; in especially cold climates, the wool fat content can be increased, and the wax omitted.

A word of caution is indicated regarding the dangers from the indiscriminate use of penicillin ointments and solutions in trivial conditions. Instances of sensitization have been reported. The author has seen three such cases. In all three, penicillin has been used as eye drops for previous conjunctival infections. Following the use of penicillin solutions in the eyes, weeks or months later, these patients developed the typical findings of allergic dermatitis of the eyelids and conjunctiva. An intradermal test, using a .1 cc. of 1 cc. = 2,500 unit concentration of penicillin in normal saline, was done in one case at the time of the allergic lid reaction. The test was strongly positive. It is obvious that these cases might encounter serious difficulties should the parenteral administration of penicillin become necessary at a later date.

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# A COMPARISON OF VACCINE PRODUCTS AND BRUCELLERGEN IN THE INTRADERMAL TEST IN BRUCELLOSIS

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The diagnosis of brucellosis, particularly in its chronic form, is, at best, difficult and subject to erroneous results. The tests available for diagnosis should be standardized as much as possible. This is especially true of the intradermal test.

The dosage of antigen used for an intradermal test should be such as to fulfill several criteria. First, it must contain enough specific protein to stimulate a reaction in sensitive individuals. Second, this reaction should be such as to persist over a period of several days. Third, there should be no systemic reaction. Fourth, local necrosis should not occur. Fifth, it should not produce false-positive reactions.

In the past, vaccine preparations have often failed to satisfy all or most of these criteria. Local necrosis has been common following their use. Systemic reactions have often been severe. False-positive reactions have been noted by several workers, notably Favorite and Culp.[1] For this reason there has been a constant search for products which would fulfill the necessary criteria for diagnosis without producing unfavorable responses. Brucellergen, developed by Huddleson, is the most commonly used preparation of this type. Others have prepared "fat-free antigen,"[2] "purified brucella protein,"[3] et cetera, as skin-test material. Various advantages are claimed for these products, the main one being the absence of severe local and general reactions. Goldstein[2] also felt that the fat-free product did not increase the agglutination titre. As one surveys the literature, there is found a marked variation in the dosage of heat-killed organisms used in intradermal testing. Angle and his co-workers[4] used .04 cc. of a vaccine containing six billion organisms per cc. (skin test dosage therefore being 240 million organisms). They compared the results, using this vaccine in one arm and Brucellergen in the other arm, in 163 adults. They found more severe reactions with the vaccine, and a higher percentage of positive reactors than with the Brucellergen. Keller[5] also compared Brucellergen and vaccine. He used a vaccine preparation which gave him a skin-test dose of 60 million organisms (half-and-half B. abortus and B. suis). In 76 cases he found 73 positive with the Brucellergen and 74 with the vaccine. The local reactions were approximately equal in size. There were no abscess formations. Seven of the patients developed vesicles with the vaccine, and only one with the Brucellergen. These 76 cases were known to have

† Captain Urschel is a resident of Mentone, Indiana.

[1] Favorite, G. O., and Culp, C. F.: The Intradermal Test in Undulant Fever, *J. Lab. and Clin. Med.*, **20**:522, 1935.

[2] Goldstein, J. D.: Cutaneous Reactions in the Diagnosis of Undulant Fever, *J. Clin. Invest.*, **13**:209, (March) 1934.

[3] Morales-Otero, P., and Gonzalez, L. M.: Studies on a Purified Antigen from Brucella, *Am. J. Med. Sci.*, **199**:810, 1940.

[4] Angle, F. E.; Algie, W. H.; Baumgartner L., and Lunsford, W. F.: Skin Testing for Brucellosis (Undulant Fever) in School Children, *Ann. Int. Med.*, **12**:495, (October) 1938.

[5] Keller, Alvin E.: Comparisons of Skin Reactions Obtained by the Use of Brucellergen and of Heated Brucella Organisms in Sensitized Individuals, *So. Med. J.*, **33**:1180, (November) 1940.

been reactors to the skin-test two years before. Favorite and Culp first used a vaccine with a skin-test dose of 80 million organisms. However, they found this to be too strong and changed to one which gave them only 8 million organisms per skin-test dose. Lewin and Gersh[6] used 60 million organisms. Goldstein used 25 million organisms (Strain 80, Brucella abortus) and found a high percentage of lymphadenitis and local necrosis. Sixteen of his 26 positive reactors developed fever, and 20 had a generalized reaction. Kirby and Rantz[7] used 40 million organisms (half-and-half abortus and suis) and found no higher percentage of lymphadenitis with vaccine than with Brucellergen. They found no higher development of agglutinins with vaccine in this dosage than with Brucellergen.

The interpretation of the test also varies widely. Huddleson feels[8] that erythema alone is of no significance, but that erythema and induration more than two centimeters in diameter must be regarded as a positive test. Some men read the test in twenty-four hours, but forty-eight hours has been generally accepted as the optimum time, because by that time the false-positive erythema has cleared. For this same reason some investigators feel that the test should not be read before ninety-six hours, and one group waits a week. Certainly, if one waits a week there will be no false-positive reactions remaining, because by that time all erythema is gone and the characteristic induration of a positive test remains. However, in criticism of this method, it may be said that tests may react positively, and still not give enough induration to remain for a week. It must also be remembered that even a strongly positive skin reaction is not sufficient evidence, by itself, of active undulant fever. It would be just as erroneous to consider every positive tuberculin as an indication of active tuberculosis. The skin reaction in both of these diseases is evidence of sensitivity to a specific protein, and is not an index of activity of infection.[9] Another phenomenon which must be watched for in skin testing for brucellosis is the delayed positive reaction, which may not appear until the fifth day or later. A good standard procedure is this: the patient is observed at the end of forty-eight hours. If induration and redness of two centimeters or more is present, it may be considered a definite positive. If redness is present without induration, or if the indurated area is very small, the patient should be observed at two-day intervals for a week. With rare exceptions the true positive reaction will last four days or more.

[6] Lewin, J. R., and Gersh, I.: Immunologic Reactions for Undulant Fever in Apparently Healthy and in Tuberculous Children, *J. Ped.*, **12**:571, (May) 1938.

[7] Kirby, W. M. M., and Rantz, L. A.: The Agglutinin Response of Normal Persons to Skin Tests with Brucellergen and Brucella Vaccine, *J. Lab. and Clin Med.*, **27**:1244, (July) 1942.

[8] Huddleson, I. F.: *Brucellosis in Man and Animals*, Commonwealth Fund, Publishers, 1943.

[9] Urschel, D. L.: The Diagnosis of Chronic Brucellosis, *J. Ind. St. Med. Assoc.*, **26**:59-63, (February) 1943.

### METHOD

In this study, four different antigens were tested. Brucellergen was used in 1-12000 dilution. 0.1 cc. was used as the skin-test dose. Antigen No. 2 was a commercial undulant fever vaccine, which contained, per cc., 1000 million each Brucella abortus and Brucella suis. For skin testing, this was diluted with a prepared diluent, so that a skin-test dose of 0.1 cc. contained 33 million organisms. Antigen No. 3 was a specially prepared suspension of heat-killed Brucella abortus organisms, each cc. containing 2000 million organisms, and antigen No. 4 was a similar suspension of heat-killed Brucella suis organisms. They were likewise diluted with prepared diluent so that 0.1 cc. contained 33 million organisms.

The method of testing is shown in Table I. One hundred fifty-eight patients were tested, of whom sixty-three gave positive reactions. When mixed vaccine and Brucellergen were compared, the vaccine was placed in one forearm and the Brucellergen in the other. In comparing B. abortus, B. suis, and Brucellergen, the latter was placed on the left forearm, while the right forearm was used for the other two, the tests being placed far enough apart so that their areas of erythema would not be superimposed. For the purpose of this paper, the results are recorded according to the size, in millimeters, of the erythema. Because of the anatomy of the forearm, the erythema was almost always oval, and the reaction sizes recorded are the vertical and horizontal dimensions.

For this paper, no effort was made to record generalized reactions. When two or three antigens were tested simultaneously, it was obviously impossible to tell which was producing systemic symptoms.

**TABLE I**

**METHODS OF TESTING, WITH PERCENTAGES OF POSITIVE REACTIONS IN EACH GROUP**

| | *Total* | *Positive* | *Per Cent* |
|---|---|---|---|
| Comparison of Abortus, Suis, and Brucellergen | 38 | 17 | 44.7 |
| Mixed Vaccine and Brucellergen | 18 | 9 | 50 |
| Mixed Vaccine alone | 97 | 36 | 37.1 |
| Brucellergen alone | 5 | 1 | 20 |
| Totals | 158 | 63 | 39.8 |

### RESULTS

In Table II is shown the comparative size of the reactions in those patients who reacted positively when tested simultaneously with B. abortus, B. suis, and Brucellergen. It is well known that, clinically, the suis strain of the organism produces the most serious disease. I had been of the opinion that the undue reactions noted in the use of mixed vaccine might be caused by the presence of the suis organism, and this is partly substantiated by the findings in this series of cases. Not only was there more

local necrosis, but the size of the reaction was 50 per cent larger with B. suis than with B. abortus.

TABLE II

COMPARISON OF REACTIONS IN SEVENTEEN CASES WHICH GAVE POSITIVE REACTIONS WHEN TESTED SIMULTANEOUSLY WITH ABORTUS VACCINE, SUIS VACCINE, AND BRUCELLERGEN

| | | Local Necrosis | | Lymphangitis | |
|---|---|---|---|---|---|
| *Reagent* | *Size Reaction* | *No.* | *Per Cent* | *No.* | *Per Cent* |
| Abortus | 21.5 x 23.5 | 1 | 5.9 | .... | ..... |
| Suis | 31.7 x 35.3 | 2 | 11.8 | .... | ..... |
| Brucellergen | 28.4 x 32.2 | .... | ..... | .... | ..... |

In Table III are shown the results in nine cases which reacted positively when tested simultaneously with vaccine and Brucellergen.

TABLE III

COMPARISON OF REACTIONS IN NINE CASES WHICH GAVE POSITIVE REACTIONS WHEN TESTED SIMULTANEOUSLY WITH MIXED VACCINE AND BRUCELLERGEN

| | | Local Necrosis | | Lymphangitis | |
|---|---|---|---|---|---|
| *Reagent* | *Size Reaction* | *No.* | *Per Cent* | *No.* | *Per Cent* |
| Vaccine | 19.2 x 22.5 | 1 | 11.1 | 2 | 22.2 |
| Brucellergen | 15.0 x 17.2 | .... | ..... | 2 | 22.2 |

Table IV shows the results in the cases which were tested with mixed vaccine along or with Brucellergen alone.

TABLE IV

STATISTICS REGARDING POSITIVE REACTIONS IN CASES TESTED WITH MIXED VACCINE ALONE, OR WITH BRUCELLERGEN ALONE

| | | | Local Necrosis | | Lymphangitis | |
|---|---|---|---|---|---|---|
| *Reagent* | *No. Cases* | *Size Reaction* | *No.* | *Per Cent* | *No.* | *Per Cent* |
| Vaccine | 36 | 22.3 x 23.2 | 3 | 8.3 | 1 | 2.8 |
| Brucellergen | 1 | 20 x 20 | .... | .... | .... | .... |

Table V summarizes the reaction sizes and percentages of necrosis and lymphangitis in the entire series. It may be seen that the size of the reaction was almost identical in the abortus-tested cases, and in those in whom mixed vaccine was used. The suis organism provoked the greatest reaction, while brucellergen was midway between the other two. When the percentage of local necrosis is analyzed, however, there is a significant difference. The suis organism, as expected, produced the most severe reactions and the most local necrosis. Mixed vaccine, which contains both B. suis and B. abortus, produced almost as many cases of tissue breakdown.

TABLE V

SUMMARY OF ALL SKIN TESTS WHICH GAVE POSITIVE REACTIONS

| | | | Local Necrosis | | Lymphangitis | |
|---|---|---|---|---|---|---|
| *Reagent* | *No. Cases* | *Size Reaction* | *No.* | *Per Cent* | *No.* | *Per Cent* |
| Abortus | 17 | 21.5 x 23.5 | 1 | 5.9 | .... | .... |
| Suis | 17 | 31.7 x 35.3 | 2 | 11.8 | .... | .... |
| Mixed Vaccine | 45 | 21.7 x 23.1 | 4 | 8.9 | 3 | 6.7 |
| Brucellergen | 27 | 23.6 x 26.8 | .... | .... | 2 | 7.4 |

The pure abortus vaccine produced the least damage of any of the killed organism suspensions. Brucellergen caused no local necrosis, but did show a higher percentage of lymphangitis than any of the other preparations.

There were no cases in the series in which a significant reaction occurred to one antigen while others were negative.

## COMMENT

It is obvious from this study, representing tests done on patients from a brucellosis endemic area (northern Indiana), that heat-killed vaccine preparations are not preferable for routine skin testing. Even when the vaccine products were diluted below the dosage usually suggested for skin-tests there was a significant number of cases in whom local necrosis occurred.

Brucellergen is the antigen of choice in routine skin testing. It should be pointed out that it may be necessary to dilute it in testing patients in whom chronic brucellosis is suspected. When this work was done, Brucellergen was prepared in a dilution of 1:12000. Griggs[10] has found it advisable to dilute the preparation 10 times (1-120,000) for his initial testing. He has repeatedly called attention to the hypersensitivity which some patients demonstrate, and has advocated extreme dilution of vaccine products.

## CONCLUSIONS

1. Four different antigens were compared in routine skin-testing for brucellosis. Antigen No. 1 was Brucellergen 1:12,000. Antigen No. 2 was a commercial undulant fever vaccine containing 1000 million each Brucella abortus and Brucella suis per cc. Antigen No. 3 was a heat-killed suspension of Brucella abortus. Antigen No. 4 was a similar preparation of Brucella suis.

2. These antigens were compared on a basis of reaction size, occurrence of local necrosis, and occurrence of lymphangitis.

3. The B. suis preparation produced the largest reaction, followed in turn by Brucellergen, B. abortus, and the mixed vaccine.

4. The B. suis antigen produced the highest percentage of local necrosis, followed by the mixed vaccine and by B. abortus. There were no cases of local necrosis from Brucellergen.

5. Lymphangitis occurred in 7.4 per cent of those cases tested with Brucellergen, 6.7 per cent with mixed vaccine, and none with B. abortus or B. suis alone.

6. Even though the heat-killed organism suspensions were diluted to a strength of 33 million organisms per skin-test dose, there was signficantly more local necrosis with their use than with Brucellergen.

[10] Griggs, J. F.: Specific Vaccine Therapy of Chronic Brucellosis, *J. Ind. St. Med. Assoc.*, **37**:241-245, (May) 1944.

*THE JOURNAL*

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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JANUARY, 1945

# Editorials

## 1945

Again we begin a New Year—1945 dawns upon us with a lot of questions in our minds: What will the New Year bring to us? What will it mean to us? These questions, of course, cannot be answered. It is not given to mortal man to foresee what the morrow will bring. We may surmise; we may speculate; but each day's problems are unfolded as the day dawns. We can only hope, hope for the brighter side of things. With the whole world in turmoil, engaged in the slaughter of human beings—all because of the weird workings of the minds of megalomaniacs, and with a large percentage of the youth of our nation engaged in battle for their very existence, one wonders how any of us are able to maintain anything approaching a normal state of mind.

Yet, with all these forebodings, with all these actualities that now exist in our daily lives, THE JOURNAL makes bold to wish our members a *Happier* New Year. May it come to pass that ere the year closes the world picture will be brighter; may we again be able to look beyond a bit, toward the better side of things; and, finally, may the New Year bring us P E A C E !

HAPPY NEW YEAR!

## SECRETARIES-EDITORS' CONFERENCE

This annual meeting was held at the A.M.A. headquarters on November 17 and 18, with an unusually large attendance. Formal discussions on the first day of the program were: "The Functions and Operations of the Bureau of Information," by Lieutenant Colonel Harold C. Lueth, Army Medical Corps, Liaison Officer; "The Council on Medical Service and Public Relations," by John H. Fitzgibbon, Chairman of the Council; "The EMIC Program," by E. D. Plass, of the State University of Iowa, and Thurman B. Rice, State Health Officer of Indiana; and "Medical Service Plans," by Robert E. S. Young, Member of Medical Service Committee, Ohio State Medical Association.

All these papers were well received and elicited much discussion, probably more than in former years. This is but another evidence that American Medicine is fully alive to matters economic, and is well equipped for such discussions.

On Friday evening the annual dinner was held at the Palmer House; this is officially known as the "Dinner Meeting for Editors of State Medical Journals," but of late years it has become a free-for-all, about ten aliens for every editor being in attendance. This is not said in complaint, save that these "furriners" barge in, take the choice seats at the table and get the "Chef's Special," while the lowly editors get what is left in the kitchen.

However, the editors managed to have the program to themselves, not much static being developed in the massive audience. One of the disappointments of the meeting was the absence of Brooksher, Secretary-Editor from Arkansas, who was scheduled to be the ringmaster at the dinner, and those acquainted with that worthy chap had anticipated some lively doings on his part. He was unable to attend for some reason or another, and Edgar Shanks, of Georgia, was named to serve in his stead. Edgar got things going right on schedule, and managed to close shop for the evening at the scheduled time.

Herman M. Jahr, Editor of the *Nebraska State Medical Journal*, discussed "Our State Journals as Molders of Opinion." This was really a scholarly address, one that showed the author to be close to his subject.

Creighton Barker, Connecticut Executive Secretary, talked on the "Attitude of State Medical Journals Toward Political and Social Trends That May Affect Medical Affairs," a title almost as long as his speech, which was short and much to the point.

The Hoosier Editor was scheduled to discuss "Our State Journals as News Services," but departed somewhat from this field and devoted much of his ten minutes to a portrayal of things as he had observed them during his brief stay in the big city. (He had spent a whole day in a formal session of the Board of Trustees, hence had a lot to talk about.)

On Saturday morning, J. W. Wilce, formerly known to the athletic-minded doctors as head coach of the Ohio State University football team, talked on "Medical Attitudes, Opportunities and Responsibilities in a National Fitness Program."

The final paper on the program was "Radio Broadcasting by the Medical Profession," by A. S. Brunk, President of the Michigan State Medical Society.

These annual get-togethers have increased both in interest and attendance in recent years, and have been of very great value to the state secretaries and to the editors of the state medical journals.

## SOUTH CAROLINA'S TEN-POINT PROGRAM

For quite some time we have been interested in watching the progress made by the South Carolina Medical Association in the matter of the adoption of some specific plan for action in medical economic matters. Their official organ has had much to say about it, and many suggestions were offered in the project.

Earlier, it had been voted to levy an assessment of ten dollars per member, and as of September first this had been collected, and the Ten-Point Program was in effect. This program, to our mind, covers the situation so thoroughly that the points involved are quoted:

*1. CO-OPERATION.*

To promote closer co-operation and better understanding between all groups and individuals concerned with providing and improving medical care for the people of South Carolina.

*2. POLITICAL CONTROL.*

To prevent political control or domination of medical practice or medical education.

*3. STUDY.*

To assemble and to amplify studies relative to the need and availability of medical care in each county of the state, and in the state at large, and to publicize these findings.

*4. CARE OF THE INDIGENT.*

To prepare a uniform plan for the hospital care of the indigent, financed by public county funds, which may be used by individual counties or groups of counties for their indigent sick, and to promote the general adoption of the plan.

*5. HOSPITAL INSURANCE.*

To make voluntary hospital insurance available to all the people of the state, and to promote the widespread purchase of such insurance.

*6. HOSPITALS.*

To study the present availability and facilities of hospitals in the state, and to promote the establishment of well-equipped and adequately-staffed hospitals in needy areas.

*7. GROUP HEALTH INSURANCE.*

To promote the establishment of group health insurance plans in all industries, large and small, in South Carolina.

*8. STANDARDS FOR INSURANCE.*

To establish standards for insurance companies selling hospital or group health insurance in South Carolina, and to publish the names of those who meet the standards.

*9. MEDICAL AND NURSING EDUCATION.*

To promote the securing of adequate funds and facilities for the operation of the Medical College of South Carolina.

*10. EDUCATION OF THE PUBLIC.*

To acquaint the citizens of the state with regard to the agencies and facilities in the fields of medical care, public health, hospital and industrial insurance, and to encourage the people to use them on a much greater scale.

Even a casual perusal of the ten points listed will convince one that practically every phase of economic medicine is covered here. From conversations with various members of the South Carolina Medical Society, and a careful reading of the discussion of this plan during the past several months, we are familiar with the many problems this group has had for consideration, and they are to be congratulated on having arrived at what we believe to be the correct solution.

While this is purely a local project, most any other state, if they do not already have a similar plan in operation, would do well to thoroughly familiarize themselves with this Ten-Point Program. We are convinced that it is workable, and that with Julian Price holding the whip hand it will prove to be a huge success in that state.

## "NATIONAL OPTICAL STORES"

This is but one of the names used by a chain of "optical stores" throughout the Middlewest. In Indiana there are several such outfits in the larger communities. Sometime ago THE JOURNAL exposed this outfit, following a visit to their Indianapolis store, this in answer to a wire asking us to drop in for a conference relative to engaging our services in their then Hammond store, which since has been closed.

From time to time we have commented on the fact that this outfit continues to solicit Indiana doctors, all well up in years, to take employment with them. Of late it would seem that they are having trouble in "manning" their establishments since an unusually large number of our members have received these bids, via post card.

One addressed to us, September 23, 1944, and signed by Anthony Sward, 1148 West Chicago Avenue, Chicago, indicated that we would have to leave town for this particular job. He said, "We can offer you a splendid remuneration. This is refraction work, *no experience necessary.*"

We at once answered the inquiry, asking for further information, although our previous Indianapolis interview had given us full information as to the racket. Under date of September 28, the

letterhead being that of the National Optical Stores Company, Chicago, friend "Tony" wrote us quite a letter, which is given in full herewith:

"Dear Doctor Shanklin:

"Pursuant to your letter of September 25th.

"The proposition as the card stated is refraction work (refracting eyes). It is a permanent connection, and is very easy and interesting work. If you have not been doing this type of work recently, we are able to train you in a very short period of time.

"The minimum guarantee which we offer is sixty-five dollars ($65.00) per week. The branch offices that are available at the present time are South Bend, Muncie, Marion and Evansville.

"This requires absolutely no selling in any shape or form on your part, and is really not in the nature of a proposition, but is a bona fide offer of a permanent connection with a company of many years' standing and reputation.

"Owing to the fact that we must have a doctor available, you will realize that we are doing the best we can to make arrangements as quickly as possible.

"If you have had no previous experience in refraction work please call me (COLLECT) and I will make arrangements for you to train at one of our offices near you. While you are in training, we pay your expenses when you are away from home.

"Our bank reference is the NATIONAL SECURITY BANK of CHICAGO.

"We would esteem it a great favor if you wire or call me (COLLECT) at the above address, as to your decision, immediately."

It will be noted that Tony suggests that training might be had in one of their stores. One such store is in a neighboring city, where the "ophthalmologist" is a former member of our county medical society and who to our knowledge has had no previous training in this subject prior to his "enlistment" with this racket.

This thing has been going on for several years, right here in our own state. The reason that, as Tony says, "We must have a doctor available," is due to the Indiana Optometry Law, which put a stop to chain-store optometry in this state. However, by the clever subterfuge of employing a regularly-licensed physician, they have been able, thus far, to evade the law. On the same date the card was mailed to us, September 23, it seems that Dr. A. B. Graham, now retired and formerly of Indianapolis, was sent a card, an exact duplicate, this being forwarded to him in El Paso, Texas. (It is evident that Tony is using an old directory, since Doctor Graham has not been listed at Indianapolis for some years.) Doctor Graham writes, "Why my name was drawn from the hat, as a possible gullible victim of this damnable racket, I do not know."

Folks, *this is a racket*, and a racket that can be scotched! How long shall we permit this outfit to evade the intent and purpose of the Medical Practice Act and the Optometry Law? Hundreds of the gullible answer the advertisement of these Indiana stores, pay their money in good faith, and what do they get? They get an "examination" by a doctor, *a regularly-licensed doctor;* they are led to believe that these men are "eye doctors," which they are not. They are but doctors who have sold their medical birthright, probably because this racket offers more cash remuneration than they were able to make in regular practice.

We of Indiana have cleaned up some rather nasty messes about the state; we can clean this one up in short order if we but get to it. Further, it is entirely possible, under the existing medical laws, to revoke the licenses of these medical offenders — a thing that should be done — NOW!

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## "G.I. JOE" WRITES A LETTER

On last Thanksgiving Day the *Chicago Tribune* printed a first-page letter that will be of more than common interest to every physician. In addition to the Thanksgiving sentiment, the letter makes two references to the sort of medical care he and his buddies are receiving "over there." In fact, he makes it clear that it is probable that had it not been for the skill possessed by the Medical Corps officer the letter would not have been written.

This letter was mailed, in advance of the Holiday, to Dr. Irving S. Cutter, a friend of the writer and editor of one of the finest, most common-sense health columns in the country.

We have the permission of the *Tribune* to reprint this letter:

" 'Italy, October 20, 1944.

" 'Dear Mother and Dad:

" 'I want this to reach you on turkey day, hence am sending it through one of our friends. This season has always meant so much to us, and believe me its significance has multiplied a thousandfold in my heart.

" 'I can see mother and Mary bustling about the house getting everything ready, and I suppose that Uncle John, Aunt Kate, and all the relatives will be over. I'll sit right beside you, mother, after dinner is over, when everyone gathers around the fireplace. Somehow or other, Thanksgiving Day seemed to bring us closer together, and I can recall every celebration since I was able to toddle around. They were all happy times—not only because of the pies, nuts, and other goodies, but we all felt that we belonged to one another.

" 'You know how enormously proud I am of you. Everything that I am I owe to my parents. I can never be sufficiently grateful, no matter what comes. This is my third Thanksgiving away from home. The first was in camp, the second in Africa, and now here. At first I wasn't lonesome, but I'm telling you now that I am. Yet I can see every spot in the house, and please don't make any changes. When I get back, I want to find it just as it was when I left.

" 'I have a confession. I was wounded at . . . It was touch and go for a day or two, but, thanks to our wonderful Army doctors, I am right side up. Am walking around under my own power. I never realized what grand chaps many of these physicians are. One of them told me about the new remedy they used, and that stuff, with blood plasma, saved my life. I was fortunate enough to land with a hospital crowd from one of our big medical schools. This all explains why your usual letter did not reach you. Before my detachment was sent on its mission, I wrote you that you wouldn't hear from me for quite a spell. Well, it's over, and this is a real Thanksgiving!

" 'After the company has all gone and you and dad are alone, please put out the lights, just as we used to do. We will watch the flickering shadows cast by the blazing logs. Then perhaps dad will lead while we hum some of

the old familiar tunes. After a bit you will go to the piano and run your fingers softly over the keys—maybe a hymn or two mixed with snatches from Debussy. Then there will be silence except for an occasional crackle from the grate. I like quiet when it tells me that you are near.

" 'Pretty soon dad will yawn and say, "Well, son, it's time for you to get your beauty sleep."

" 'It's been wonderful to be at home this year. Tomorrow I'll rejoin my company. They are on rest billet just now. Don't miss a chance to tell all our neighbors who have sons or daughters over here that they need not worry about illness or wounds. Our medical men are the best in the world, and so are the nurses.

" 'Take care of yourselves, and don't get too tired.

" 'Heaps of love,

" '_____.' "

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# Editorial Notes

There seems to be an increased activity in Procurement and Assignment circles. While the Army has announced that for the nonce they have enough men in their Medical Corps, the Navy has asked for a large increase in that direction. Already some local men have been contacted in the matter.

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One thing which physicians might do well to fix in their minds is the fact that sixty-six per cent of the American people think that their doctors are "tops," according to a recent survey of the matter. The sixty-six per cent may not seem so high after all, but in these days of carping criticism any group that comes out with such a ranking might well pat themselves on the back and say, "Well, we *are* good!"

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The medical superintendents of our state hospitals, five in number, seem agreed that there should be a sixth hospital for the care of mental cases, and that it should be located in the northern section of the state. It is a deplorable fact that all state institutions are now overcrowded, and with the increase in the number of mental patients that surely follow war activities, it would seem that we must do something about it.

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A down-state paper, in discussing hospital facilities, correctly states that in our postwar planning we will need to give due attention to an increase in hospital beds. The editor goes on to comment on some of the things that hospital folk would like to come to pass; he says that they want more artistic furniture, gayly-colored wallpaper for all rooms, complete air conditioning, "radiant heating," and a communication system that will permit the patient to talk to the floor nurse from his bed. Dust-control contrivances are also in the list. One can but wonder just what the hospital rates will be if all these gadgets are placed in operation.

We quite agree with many writers, both lay and professional, that group medical care will be one of the problems to be seriously considered after the end of the war. There are many things in its favor, especially in the larger centers, and many of the men now in service have expressed themselves as being highly in favor of some such plan.

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As the world-wide war goes on, and as the casualty list continues to mount to huge figures, the work of the Army and Navy Medical Corps continues to command the admiration of not only the heads of these departments but of the people of all nations. It is definitely decided that no other nation equals America in the successes achieved in regard to its casualties. The generals in charge of these fighting divisions, busy as they are, take time out to tell war correspondents their views concerning the Medical Corps. Postwar medical history will, indeed, be an interesting volume.

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The *Anderson Herald*, in commenting on the remarks of Dr. John H. Fitzgibbon, chairman of the Council on Medical Service and Public Relations of the American Medical Association, closes its statement by saying, "Here is a case where the critics are seventy years behind the doctors." Fitzgibbon had stated that as long as seventy years ago it was suggested by the organized medical profession that the Federal Government establish a health agency, with a secretary of Cabinet rank. That was a long time ago, the year in which we were born, in fact, so we knew little about it until some years later. However, during the more than forty years with which we have been actively connected with medical organizations this recommendation has been made repeatedly.

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The annual session of the American Medical Association will be held in Philadelphia, June 18-22, 1945. With hotel reservations being what they are, and train reservations even more complicated, it behooves Hoosier medics who plan to attend this meeting to make such reservations at once. We are advised that many physicians choose to make their reservations at Atlantic City hostelries, the train service to Philadelphia from that city being unusually good. It is but a fifty-minute ride between these points. And while making these reservations, you might as well go all the way and also make your reservation for the state association meeting, come next October, at French Lick. Tom Taggart and his gang will take especially good care of those making advance reservations.

The Woman's Auxiliary to the Indiana State Medical Association cordially invites the wives, sisters and mothers of doctors to become members at large, in the event that their local counties are not organized.

We frequently have been asked as to the stand of THE JOURNAL in the matter of health insurance plans, it being noted that our editorial columns are singularly free from such discussions. Our policy in such matters has been of the "hands off" variety when they pertain to affairs that arouse such widespread discussion as has this question. In four decades we never have known of a single problem that has been so widely discussed and that has aroused such intense pro and con arguments. Some of our county societies have taken drastic action, some are as yet noncommital, while others are strongly in favor of adopting some workable plan. THE JOURNAL is disposed to sit on the sidelines rather than attempt to *sway* Hoosier medical opinion. A long time ago we learned that we got along much better if we but *reflect* Hoosier medical opinion!

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At the annual session of the Indiana State Medical Association, the House of Delegates voted an assessment of five dollars per year for all members, this "for the duration." This was made necessary due to the marked increase in the activities of the association, all of which were ordered by the House of Delegates and the Council. What with more than a thousand members now in service, all of whom are absolved from payment of dues, our income has been greatly decreased. While it is true that our treasury shows a sizeable balance, it was deemed wise that this surplus should not be used at this time. No one can foretell just when this money will be sorely needed, and a good cash balance always will "come in handy." This temporary increase in dues should prove to be no hardship on any member; we are all busy, and while it is true that we are constantly called upon for "donations" for various causes, a small additional contribution to our treasury will help us maintain the "forward looking" schedule we have before us.

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Due to a lot of things, 1945 will be one of the busiest years in the history of the Indiana State Medical Association. The headquarters office will be put to it to get things done; it will be a veritable beehive right at the start of the year. With the General Assembly about to open for its sixty-day session, several of our group will be extraordinarily busy; material to be mailed to all county medical groups will have to be gotten out; a watchful eye must be kept on the doings of the new Congress which will bring to light many matters of more than common interest—all of this means that your official family will be busy, no end. You, each member, can help materially right off the bat; if every member would pay his annual dues as of the first of the year, it would mean but a day or two for the headquarters office to enter these items and close the books for the year. However, many do not do this; dues come filtering in, day by day, taking a lot of unnecessary time on the part of Miss Reid. PAY YOUR DUES TODAY!

The "carbon monoxide poisoning" season is here, and it would be well for physicians to stress the danger of operating car motors in a closed garage; in fact, physicians themselves would be wise to guard against such a thing. Many of them are dead tired when they arrive home, and all too often it is a temptation to stay in the car for a moment before stepping out. One man had such an experience last winter, and he was extremely fortunate in waking from a little doze in time to get to the open air.

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Evan Wright, director of the Food and Drug Division, Kansas State Board of Health, makes bold to offer the following declaration to American housewives: "Read the labels on your food! If they contain either sulfur dioxide or benzoate of soda you may rest assured that they are inferior products, because properly processed foods do not need chemical preservatives." He then states that the better food manufacturers get along without these chemical preservatives, which he declares to be sufficient proof that they are not necessary. His article, printed in the November number of *Hygeia*, will be read by many housewives who, no doubt, will at once begin scanning the labels of the prepared foods they purchase. It is not so long ago since most tomato products, including the almost universally-used Catsup — Ketchup, if you prefer — contained benzoate of soda as a preservative, and well do we recall the fight that the late Doctor John N. Hurty made against this practice, finally winning his long battle.

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In the dozen years we have had a bit to do with THE JOURNAL there have been many quaint happenings of one sort or another, but "tops" along that line came to our notice a few days ago. It has been our custom to order about thirty extra copies printed each month, these to be mailed out as requests for them come in. But in the last month or two there has been a shortage — for November this amounted to just thirty copies, hence we had no extras for our own use. In checking with an official of our printing company, we were advised that he would investigate the matter for us. He did, and his reply is quoted: "There may have been a larger spoilage than usual, but in addition to this I find that we also have another problem: you are making your magazine so interesting that we just cannot let it lie around. Not only do our own employees like to read it — they stick a copy in their pocket so they can take it home to read, because it is good reading, but we have actually caught others in the building going down to the mailing room, after we have sent THE JOURNAL down there, and walking out with copies. There is no question about it—you are putting out the finest magazine in the country, in that field." Well, now we know why the shortage exists; we knew we were good, but not exactly *that* good!

# President's Page

## I HAVE FAITH

You are a busy doctor—so are all of us—but if, by chance, you have a moment to read this, my first president's message, may I ask you to take a few moments to really think it over. Believe me, your interests and mine are certainly involved, and consequently I must be conscious of the things you are thinking about in regard to the future of medical practice. You and I have gone along for so many years in our methodical way in the practice of medicine that we have perhaps overlooked the fact that the accumulating inroads into our way of doing things have been accepted as something related to the common welfare of those we serve. Do you remember any one thing that has been presented as a public health measure that hasn't met the full cooperation of the medical profession? I don't, and yet every one of these propositions has taken away from the practicing physician a certain measure of his heriditary rights in the pursuit of the healing art. What profession on this earth gives so freely of its time to educate the young men and women who will follow them in the proper methods of caring for the sick?—this without compensation, in the majority of instances, to instruct those who will soon become their competitors. What group, in the whole world, provides over a million dollars daily, measured in dollar terms, in free advice and care to those in need of medical attention without a thought or qualm about who is going to be paid, by whom or when? Name one body of men who are so intently interested in their work that they permit outside influences to creep into the administration of their affairs while they pursue their work entirely wrapped up in the interests of the sick.

Give me a similar instance of a group, whose sincere and entire interests are employed in the healing of the sick, who are continually besieged by unqualified opportunists seeking through legislative means to destroy the standards they have established through years of struggle and adherence to a sublime faith in the belief that the patient and his sickening troubles are their primary concern and interest, always.

No other institution in the history of the world, and I do not except the ministry, has given so much to humanity as the doctor.

There are a few deep-rooted concepts in the conscience of our profession, and the outstanding one is a sense of inviolable obligation of personal and professional fidelity to the sick. Those who do not feel that obligation we class as quacks, and are not hesitant to bestow the title of "charlatans" upon them.

We like to think that the doctor stands side by side with the minister of God in readiness to relieve personal suffering and to override the weariness of human afflictions. We take great pride when our efforts have been successful in defeating the Grim Reaper; we are subdued when our attempts have yielded to the decree that "all men must die."

These trials are never given in the contemplation of the paltry dollar, but they are given because every doctor—who is a real doctor—feels that he has a certain divinity within him that glorifies his calling and demonstrates his right to belong to it.

I have a supreme faith in the democracy of America as I have the highest faith in the ability of the medical profession to withstand the onslaughts of those who seek, for their own private gain, to encroach upon the field of medical practice. Their interests are political and monetary. Ours are founded upon the welfare of humanity. On such a basis we should have no fear that ours is the right, and that right will prevail. Surely, the medical profession itself can find the solution to most of our problems.

N. K. Forster

# SECRETARIES' CONFERENCE

## INDIANA STATE MEDICAL ASSOCIATION

### RILEY ROOM, CLAYPOOL HOTEL

INDIANAPOLIS

Sunday, January 21, 1945

1:00 p.m. Call to order and opening remarks by A. M. MITCHELL, M.D., Terre Haute, chairman.

1:15 p.m. Welcome to secretaries by J. E. FERRELL, M.D., Fortville, president-elect, Indiana State Medical Association.

1:20 p.m. "The Bolton Law and Its Relationship to the Patient," MARY WALSH, educational director, State Board of Examination and Registration of Nurses, Indianapolis.

1:30 p.m. "Group Malpractice Insurance and Health and Sickness Insurance," DON C. HAWKINS, special agent, American Health Insurance Corporation, Chicago, Illinois.

2:00 p.m. "Children's Bureau Program," JOHN D. VAN NUYS, M.D., medical director, Indiana University Medical Center, Indianapolis.

2:20 p.m. "Legislative Program," NORMAN M. BEATTY, M.D., and J. WILLIAM WRIGHT, M.D., Indianapolis, co-chairmen, Committee on Public Policy and Legislation.

2:50 p.m. General discussion.

3:10 p.m. Recess.

3:15 p.m. "American Medical Association Council on Medical Service and Public Relations," JOHN H. FITZGIBBON, M.D., chairman, Portland, Oregon.

3:45 p.m. "How Local Societies Are Meeting Present Emergencies," O. E. WILSON, M.D., secretary, Elkhart County Medical Society, Elkhart.

4:10 p.m. "Postwar Medical Practice," LIEUTENANT COLONEL HAROLD LUETH, Liaison Officer, Army Service Forces, Surgeon General and the American Medical Association, Chicago, Illinois.

4:40 p.m. "Journal of the Indiana State Medical Association," E. M. SHANKLIN, M.D., editor, Hammond.

4:50 p.m. Questions and answers.

5:15 p.m. Election of chairman for 1945.

Adjonrnment.

### Evening

6:00 p.m. Dinner, Riley Room, Claypool Hotel.

Speakers: N. K. FORSTER, M.D., Hammond, president, Indiana State Medical Association.

CONGRESSMAN WALTER JUDD, Minnesota.
"Problems Facing the New Congress and the American People."

*(All members of the Indiana State Medical Association are cordially invited and urged to attend.)*

# FEDERAL DIRECTIVE SERIOUSLY AFFECTS MEDICAL PRACTICE IN INDIANA

The United States Government, through The Children's Bureau of the United States Department of Labor, has for a number of years made financial contributions to medical treatment programs for children in most of the states. The financial contributions are made through the familiar fund-matching plan whereby the Federal Government allots a sum of money to be used for medical treatment provided the state contributes a like or larger sum for the same purpose. The Division of Services for Crippled Children of the Indiana State Department of Public Welfare has accepted federal money for use in the care of crippled children for a number of years. The federal contribution in Indiana, however, for the care of crippled children is a relatively small amount compared to that spent by the counties and state.

In order for the welfare department to receive the federal appropriation, it is necessary that the Division of Services for Crippled Children submit a plan of operation to The Children's Bureau of the United States Department of Labor for approval. This is done on an annual basis. By threatening to withhold approval of the plan as submitted by the state division, The Children's Bureau may exert pressure on the state to include rules of operation of their own design in the state plan. Refusal of the state to comply would mean the withdrawal of federal funds.

From time to time during the year The Children's Bureau issues directives carrying the force of law to "assist" the state divisions in drawing up an acceptable plan of operation for the next fiscal year. A directive of this type has come to the attention of the Executive Committee of the Indiana State Medical Association, and is as follows:

"U. S. Department of Labor
Office of the Secretary
Washington, D.C.

"Title 42—Public Health

"Chapter II—U. S. Children's Bureau

"Part 202—Services for Crippled Children

"Pursuant to the authority granted by section 1102, 49 Stat. 647, 42 U.S.C. 1302; section 513, 49 Stat. 632, as amended by section 506, 53 Stat. 1381, 42 U.S.C. 713, the following amendment to section 202.4 of the regulations (42 C.F.R. Part 202) relating to services for crippled children is herewith issued:

"Section 202.4 is amended by inserting, after the second sentence thereof, the following provisions: 'Effective July 1, 1945, it shall be a condition of approval of a plan that it provide that diagnostic services will be made available thereunder to crippled children without restrictions as to race, color, creed, economic status, legal residence, age (except as to persons above the maximum age for which such services are legally available within the state), the necessity of referral by any person other than the child's parents or legal guardian, or similar restrictions inconsistent with the free availability of such services.' (Sec. 1102, 49 Stat. 647, 42 U.S.C. 1302; Sec. 513, 49 Stat. 632, as amended by Sec. 506, 53 Stat. 1381, 42 U.S.C. 713).

"November 17, 1944.

"Approved Recommended.

/s/ Frances Perkins
Secretary

"/s/ Katharine F. Lenroot
Chief of the Children's Bureau

(seal)

"I hereby certify that this is a true copy of the original.

/s/ Peter Seitz,
Principal Attorney."

The Indiana University Medical Center and the hospital centers at Fort Wayne and South Bend that work with the Crippled Children's Program in Indiana would be required to accept children without reference by physicians and without concern as to their ability to pay for the service. It may be pointed out that this directive concerns examination for diagnosis only, and does not provide for the treatment of patients; however, opening the doors of public institutions for diagnostic purposes without referral by anyone other than the parent or guardian of the child and without regard for economic status would place these public institutions in the practice of medicine. Since the operation of this directive is in direct conflict with the established policy of the Indiana University School of Medicine and hospitals, the Medical Advisory Council of the School of Medicine, after considering the directive, passed the following resolution:

WHEREAS The Children's Bureau of the United States Department of Labor has issued a directive having the force of law, effective July 1, 1945, withholding approval of any state plan relative to the care of crippled children that sets up any restriction as to race, color, creed, residence, economic status, or referral of the child to a clinic or hospital for diagnostic purposes by anyone other than the parents or legal guardian, and

WHEREAS the acceptance of any child for diagnosis without restriction as to economic status and referral of children by the parents

or legal guardian only is in conflict with the established policy of the Indiana University Medical Center; therefore

Be it *Resolved* that if the above-mentioned directive is placed in force on July 1, 1945, and if the Division of Services for Crippled Children of the Indiana State Department of Public Welfare adopts the directive and makes it a part of the administrative rules and regulations governing the operation of the Crippled Children's Program in Indiana, that we earnestly request the Board of Trustees of Indiana University to authorize the Indiana University Medical Center to withdraw from participation in the Crippled Children's Program of the Indiana State Department of Public Welfare as of July 1, 1945, and

Be it further *Resolved* that the Indiana University Medical Center continue to receive crippled children of the State of Indiana for diagnosis and treatment under the welfare hospital commitment program, so that no eligible and needy child of the State of Indiana will be denied clinic or hospital examination and treatment as a result of the action of the Council, and

Be it further *Resolved* that the Dean of the Indiana University School of Medicine inform the Board of Trustees and President of Indiana University of this action of the Medical Advisory Council.

Resolution Passed by the Medical Advisory Council of the Indiana University School of Medicine, December 10, 1944.

This resolution, passed by the Medical Advisory Council of the Indiana University School of Medicine, received the unanimous approval of the Executive Committee of the Indiana State Medical Association at its regular monthly meeting on December 10, 1944. The committee of the state association further went on record stating that "we should use our efforts in every way possible to support the policy of the medical school in its refusal to support this directive."

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# WHAT THE PROFESSIONAL MAN EXPECTS FROM HIS CHAMBER OF COMMERCE *

NORMAN M. BEATTY, M.D.†

INDIANAPOLIS

It is indeed a pleasure to talk to you for a few minutes. I would like to speak to you from several points of view, talking about what a professional man can expect from his Chamber of Commerce.

In the first place, as one goes back through what has happened to civilization in recent years, say the last forty or fifty years, it is rather amazing to note the amount of new knowledge that has come, both in the professions and in business, and along with the development of this new knowledge there has come into existence numerous new organizations. Many of the new organizations are very highly specialized in their interests, and with those special interests frequently we find that the things they are concerned with are divided into two categories—number one is selfish interests for themselves which are sometimes detrimental to the general public welfare, and number two is the interest of the public and public advancement. I was rather amazed in seeing how far the specialization of thought in organization work had developed when last week at one American Medical Association meeting in Chicago I found that there were sixty-three special organizations in medicine alone having meetings at the same time. Now that is merely a sample of what is happening in business. Every new invention, every bit of progress has meant new special organizations. Every professional man has, of course, the very natural human interest in protecting his own profession and the interests of that profession, and then I hope that most of them also have a keen interest in doing something worth while for the public. So, along those two categories I would like to say a few words.

I think that you might like to know how I became interested in our own Chamber of Commerce. For the past seven years it has been my pleasure to be chairman of the Committee on Legislation and Public Policy for the Indiana State Medical Association. In that capacity I had to know something about what was happening in our state legislature that pertained to my own profession. In working around the legislature and in becoming acquainted with what was going on, I became greatly impressed with several facts. First, there were many representatives and senators who were in there as particular representatives of a special, narrow group. However, there were representatives who represented what I believe to be the community welfare, and who were interested in seeing the overall picture—who were concerned with combing out those things which had to do with special interests, and were particularly concerned with those things of general benefit to the people themselves. Outstanding among these

* Presented at the annual meeting of the Indiana Commercial Secretaries Association, June 23-24, 1944, at Fort Wayne, Indiana.

† Chairman, Public Health Committee, Indianapolis Chamber of Commerce.

groups who were interested in the general public welfare was the Chamber of Commerce. These gentlemen deserve much credit. A forward step was taken when the state chamber became so active in the state legislature.

In addition to the selfish interest which the professional man may have to protect for his own future welfare, there is that overall interest of the community. I do not believe any conscientious man can practice for very many years without developing a keen interest in the welfare of his community, as it pertains to his own knowledge. Where doctors are concerned, one of these interests is public health. Of course, many phases of public health are not particularly technical, but there are matters which require the deep concern, live interest, and real support of the people if they are to be prosecuted to the real advantage of the people. Sometimes some of the things which have to be done in the interest of public health step on someone's toes. Sometimes they arouse the antagonism of some of the selfish interests of which we speak. In order to get anywhere, you must have a forceful public health program which is backed by the citizens of the community who can arouse the interest of the entire people. I think most of us are doing something of that kind in our communities, but we are just getting started and are way behind where we should be. We are in the infancy of our program. I know one thing—without the full support of the fine gentlemen who comprise the Board, and, not the least, one gentleman by the name of Bill Book who has been secretary and the guiding light of community enterprise in Indianapolis, some things we have accomplished would never have been accomplished.

With all these specialized organizations, there is need for some organization that might be called an organization of organizations. There is a possibility, it seems to me, for the Chamber of Commerce to do something here, and that particular function, as I see it, is to carefully analyze all the desires and requests of special organizations—analyze them from the viewpoint of whether they really are for the public good. That is one of the important functions of every Chamber of Commerce.

In my own profession we have found that some of the local organizations are influenced too much by one particular segment of the community life. I can stand here and look through this room and point out some secretaries who are retail men, and whose local group is patterned pretty much around the retail business; I can pick a few others who are primarily interested in manufacturing and the employer problems; and others who may be interested in still other fields. To me that is the thing a Chamber of Commerce needs to guard against. You must constantly keep asking yourself—Are we representing all the interests of the people as a whole, or are we favoring one particular group? Only when a special organization has something that, based on an honest and careful analysis, is worth while to everyone, has it a right to your support.

One of the things we have been hearing so much about these days, that we are almost sick of the subject, is the problem of postwar planning. Most of the inspiration for that will have to come through the Chamber of Commerce. The success of it will unquestionably rest with the action of the Chamber of Commerce and organizations who have the sincere civic welfare at heart. Time alone will determine how successful these plans will be. Whether the history of postwar planning will be nothing more than a series of speeches and words without action will depend in a large degree on the amount of needling the Chamber of Commerce may give to its local officials and local interests. One of the important questions of postwar planning is what to do with the veterans, what to do with the nervous cases and disabled soldiers—I agree that will be a tremendous problem. These are some of the things that will have to be answered. The question of employment, of course, will be the number one problem, but the question of having a good, wholesome community in which to live will come next. These two factors cannot be separated. No community can thrive without an adequate public health program. I would suggest that you set up a worth-while community program and interest some of the professional men who have a genuine interest in public health to take an active part in that program.

I realize that doctors particularly have not been as interested in local Chambers of Commerce as they should have been. Unfortunately, doctors are quite busy. This was true even before the war. A good many of them feel that perhaps they do not belong with a group of business men, but I believe that during the past few years many of them have become more willing to listen, more willing to become interested in your organizations than ever before. Why? The answer is the same as with diversified business interests and with labor and agriculture, and I think it can be put in one word—"Washington." The medical profession has not escaped some of the planning for the future in Washington. There is now pending in Washington a bill that every doctor and every dentist in the United States is quite familiar with—the Wagner-Murray-Dingell Bill.

The healing arts are a business. Six per cent of the entire national income is spent in healing arts—the maintenance of hospitals, professional fees, drugs, appliances, et cetera, but it is also a very individual business, a business in which the man who is practicing deals with you as Mr. Jones and not as patient number so and so. The success of it depends on keeping this highly individualistic relationship. That is the thing that the medical profession is concerned with. It is not in the least in favor of the trend that would be started by the passage of the Wagner-Murray-Dingell Bill. To set up health protection on this basis, the deduction we have for social scurity would have to be many

times what the present deduction is. Our profession sees very definitely, from the history of what has happened in other countries where this thing has been tried, that sooner or later the doctor becomes an automat of a great inhuman governmental machine. The doctors I know will not agree in the least that this is for the public's best interest. The public will not care for it. The public will find themselves doing as they do in England, where each doctor has two entrances to his office. One is for the public patients, of which there is a very large number. He will spend a few minutes with them and pass out a little medicine. The other entrance is for the private patients, where things are handled on a personal basis. Only on that kind of an arrangement can adequate medical care be given.

The trend toward federalization in the practice of medicine and controlling of business, next to the actual prosecution of the war itself, is, I believe, the one thing down deep inside of us that every American citizen had better spend more time thinking about and doing something about than anything else. I believe that the attempt to keep control of many of these things—these services to the people—on the basis of local control is the big issue we are all going to have to be concerned with today. The medical profession and business have a common meeting ground here, for the medical profession feels that from the experiences that business has had it may have a sympathetic ear from the Chamber of Commerce and other organizations. Through that attack I believe you will find that the highly individual professional men of the past now have their ear much more open to the chance to participate with the rest of the business community interests in your Chamber of Commerce activity.

In closing, may I say that the professional man has deeply appreciated the cooperation he has had in the past. He appreciates the excellent promotional work gotten out and distributed by the state chamber and many local chambers of commerce. I hope that this is the beginning of the relationship between the professional men and the rest of the business community, as represented through your various organizations, being much more firmly cemented than ever before.

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# THE INDIVIDUAL INCOME TAX ACT OF 1944 AS IT AFFECTS INDIVIDUALS WITH INCOME FROM MEDICAL PROFESSION

WILL H. SMITH

Collector of Internal Revenue

INDIANAPOLIS

Inasmuch as a previous article covered the general provisions of the Individual Income Tax Act of 1944, the discussion that follows is concerned primarily with federal income tax requirements as they affect individuals with income from the medical profession.

The Individual Income Tax Act of 1944 simplifies some of the requirements, but it does not affect materially the problem of determining the net income from the medical profession. The statutory net income is determined by completing schedule C of Form 1040 for the year 1944. A written record of receipts and expenditures is highly important to an individual with income from the medical profession. It is intended that a taxpayer's regular accounts, files of receipts, and usual records shall be sufficient for filing income tax returns provided that actual and complete information is available and the taxpayer is prepared to prove the essential reality of claims or statements made. If a physician has other income, such income should be reported on the applicable schedules found on page 3 of the return; namely, Schedule A, Income from Annuities or Pensions; Schedule B, Income from Rents and Royalties; Schedule D, Gains and Losses from Sales or Exchanges of Capital Assets, et cetera; Schedule E, Income from Partnerships, Estates and Trusts, and Other Sources.

If a physician has income from a farm, the net farm profit is determined by itemizing the farm income and deductions on Form 1040F in the same manner as in previous years. The net farm profit as determined on Form 1040F may be properly indicated in schedule E under *Other Sources*. The Form 1040F should be attached to Form 1040 when filing. The total net income as listed on page 3 should be entered in line 4, page 1, of the Form 1040.

Physicians receiving compensation for personal services other than that reported in Schedule C should indicate such income in item 2, page 1, of the return. Total interest and dividends received is to be shown in line 3, page 1. The adjusted gross income, which was defined in the previous article, for the year 1944 is the amount shown in line 5, page 1.

Individuals whose adjusted gross income is less than $5,000 will be able to determine their tax from the optional tax table on Form 1040. The amount of tax on the table allows for personal exemption.

and personal deductions of approximately 10 per cent of the adjusted gross income. Determining tax by use of the table was not permissible in years previous to 1944 for individuals having income over $3,000.

Taxpayers who cannot use the tax table because their adjusted gross income is $5,000 or more may take a standard deduction of $500 in lieu of listing the actual items of deduction. Any taxpayer who chooses to compute his own tax may itemize his various nonbusiness deductions and credits much the same as for previous years. This would be advantageous only for those whose deductions are in excess of 10 per cent of their adjusted gross income.

If the final Form 1040 for the year 1944 is filed on or before January 15, 1945, and the tax as shown due is paid in full, the taxpayer is relieved of filing the original declaration or the amended declaration of estimated income tax otherwise required on that date. Taxpayers other than farmers must file declarations on or before March 15 of the current year, and payment of the tax may be made in four installments, which are due March 15, June 15, and September 15 of the current year, and January 15 of the following year.

Final returns on Form 1040 for the calendar year are still due on or before March 15 of the following year. The payment accompanying a final return must cover the full amount not previously paid in connection with the declaration of estimated tax or through withholdings.

# Deaths

**Frank Ridgeway Leeds, M.D.**, of Ridgeway, died November sixteenth, at the age of seventy-one. He graduated from the Hahnemann Medical College and Hospital, in Chicago, in 1899. Doctor Leeds had retired from practice.

**Joseph W. Kemp, M.D.**, of Roanoke, died November thirtieth, at the age of eighty-eight. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1891. Doctor Kemp had retired from practice.

**William Barner Karstetter, M.D.**, of Indianapolis, died December second, at the age of eighty-four. He was a graduate of the New York University Medical College, in New York, in 1884. He retired from practice a few years ago.

**Linley Murray Reagan, M.D.**, of Kokomo, died of a heart attack suffered while on a hunting trip, on November twenty-eighth. He was a graduate of the Physio-Medical College of Indiana, in Indianapolis, in 1901, and had practiced for the past twenty-two years in Kokomo. Doctor Reagan was a veteran of World War I, having served as a captain in the Army. He was a member of the Howard County Medical Society, the Indiana State Medical Association, and the American Medical Association.

**John Morton Meloy, M.D.**, of Greenfield, died December third. He was eighty-two years of age, and had retired from practice. Doctor Meloy was a graduate of the Kentucky School of Medicine, Louisville, in 1890.

**Robert M. Campbell, M.D.**, of Glendale, California, died November eleventh at his home, at the age of seventy-four. Doctor Campbell was a graduate of the Medical College of Indiana, in Indianapolis, in 1903, and had practiced many years in Tippecanoe County. Upon retirement six years ago, he moved to California.

**William P. Garshwiler, M.D.**, of Indianapolis, died December tenth at his home. He was seventy-six years of age. Doctor Garshwiler was a graduate of the Medical College of Indiana, Indianapolis, in 1896. He had been associated with the Indiana University School of Medicine for thirty-five years, having served as clinical professor of Genito-Urinary Surgery. He was certified by the American Board of Urology, and was a member of the American Urological Association. He was also a member of the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and was a Fellow of the American Medical Association.

We urge that you take this copy of THE JOURNAL home for your wife to read, for this issue contains a lot of information concerning the Woman's Auxiliary. See pages xxviii and xxix.

# Military News

A recent graduate of the Medical Field Service School, at Carlisle Barracks, Pennsylvania, is Lieutenant William D. Hart, of Anderson.

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Dr. Edwin W. Dyar, of Indianapolis, has been promoted to lieutenant commander. Commander Dyar is stationed at Pensacola, Florida.

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After being stationed at Kelly Field, Texas, Captain Edwin B. Bailey, of Linton, has moved with his outfit to Tinker Field, Oklahoma.

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While serving with the Army Medical Corps, in Burma, Dr. William B. Ferguson, of Indianapolis, was recently promoted to captain.

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After leaving Camp Rucker, Alabama, Major John W. Little, Jr., of Indianapolis, now has a New York, Army post office address.

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Lieutenant Commander Sam W. Litzenberger, of Anderson, has been home on leave recently. Commander Litzenberger is stationed at Shoemaker, California.

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A change-of-address card tells us that Captain R. C. Miller, of Indianapolis, has been transferred to Presque Isle, Maine. He was formerly at LaGuardia Field, New York.

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Lieutenant Robert M. Hansell, of Indianapolis, is on duty in England with a general hospital. He had reported that he is very comfortable and well satisfied, and even has a bicycle, but nevertheless would rather be at home spoiling his baby boy.

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A card has been received indicating that Captain Nolan A. Hibner, of Indianapolis, has gone overseas. Formerly stationed at Fort Lewis, Washington, Captain Hibner now has a San Francisco A.P.O. address.

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Major Carl S. Culbertson, of South Bend, is in Normandy, building and operating a tent hospital on a rather large scale. He states that it is surprising the amount of work that can be done in tents, and how comfortable they are. Major Culbertson says that with the exception of the elaborate plumbing facilities, they have all the conveniences that they had back in England. The morale is very high, due to the stimulation of increased work. On a recent trip to Brittany, Major Culbertson was much impressed by the pleasant atmosphere and the friendliness of the people.

Captain A. David McKinley, of Indianapolis, is serving as a flight surgeon with a fighter squadron in the Central Pacific area.

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Lieutenant Colonel Everett E. Mason, of Evansville, is a commanding officer of a medical battalion, having served in Tunisia, and also having had a part in the invasion of southern France.

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Captain A. E. Blatt recently spent a short leave in Indianapolis, coming here from Holland where he has seen service with a parachute regiment of an airborne division. Captain Blatt has also been in service in France. He received the Bronze Star while in Normandy, and a presidential unit citation.

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Major Kenneth B. Fisher, of South Bend, has been transferred from Camp Breckenridge, Kentucky, to Fort Benjamin Harrison, Indiana. Previously, he had been stationed in Alaska and South America.

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According to a news release from the War Department, Major W. C. Callaghan, of Greensburg, is on duty as chief of the EENT clinic of a station hospital. Major Callaghan has been overseas since December, 1943.

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"Just a line to let you know of my change of address," writes Captain V. K. Stoelting, of Winchester. "I am now assigned to the surgical staff at the Regional Hospital, Fort Leonard Wood, Missouri."

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In a recent letter, Dr. J. K. McBane, of Fortville, who holds the rank of assistant surgeon in the United States Public Health Service, has been transferred from the United States Maritime Officers School, at Alameda, California, to a San Francisco fleet post office address.

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Dr. Glen Ward Lee, of Indianapolis, has been promoted to lieutenant colonel, according to a recent announcement. Colonel Lee is on duty as the state medical officer of the Indiana Selective Service System, and is a member of the medical procurement and assignment committee for the state.

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While stationed in the Palau Islands, two Evansville physicians, Lieutenant Commander Albert F. Clements, and Lieutenant Robert A. Royster, had the good fortune to meet aboard a hospital ship, on which Commander Clements is stationed, when Lieutenant Royster boarded it on an errand from Pe'elieu Island. Both doctors are with the Navy Medical Corps.

Lieutenant Colonel Joseph S. Skobba, of Fort Wayne, who was in charge of the psychiatric ward at the Lawson General Hospital, at Atlanta, Georgia, for quite some time, and who has recently been sent overseas, has arrived in England. Best of luck, Colonel Skobba!

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Another Indiana physician to win recognition for his achievements is Major J. M. Kirtley, of Crawfordsville, who has been awarded the Bronze Star for the remarkable performance given by him and his detachment in caring for the wounded during the Hurtgen Forest fighting in Germany.

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Captain Richard K. Schmitt, of Columbus, has been assigned to duty at Wakeman General Hospital, at Camp Atterbury, coming there from the medical pool at Lawson General Hospital, Atlanta, Georgia, where he was recently sent for reassignment after returning from overseas duty in the South Pacific.

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Wakeman General Hospital, at Camp Atterbury, Indiana, has been designated as a special treatment center for neurosurgery, plastic surgery, ophthalmologic surgery, and neurology. Billings General Hospital, at Fort Benjamin Harrison, Indiana, has been designated as a special treatment center for histopathology, and for caring for prisoners of war.

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Captain Thomas Graham, of Lafayette, is with an Army headquarters corps at an undisclosed base, awaiting orders for further action. The members of the corps are veterans of Gaudalcanal, New Georgia, and Bougainville. Much more could be said as to its accomplishments, but for the nonce we can only say that the enemy is best aware of what they are.

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"Our organization is in New Guinea," states Captain Owen F. Benz, of Whiting. "As yet we are doing no professional work. Rain, sunshine, mud, atabrine, hash, and bully beef are the main attractions here. I heard Howard Stellner was here, so I went looking for him and found him in his tent reading THE JOURNAL of the Indiana State Medical Association."

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From England we received a letter from Captain Stephen L. Johnson, of Evansville, as follows: "Perhaps THE JOURNAL should have a more up-to-date mailing address for me. My last copy bumped around rather widely before it reached here. It's a right 'homey' addition to mail-call, or an officers' equivalent.

"It has been my pleasure to find Major James Leffel, of Indianapolis, stationed in my yard-front or back, as you please. He's chief of surgery in another general hospital.

"I have the laboratory in our hospital and am enjoying it thoroughly."

According to an announcement by the post commander, Major Russell L. Hiatt, of Richmond, has been appointed assistant commanding officer of a Medical Service Unit at Fort Sheridan, Illinois.

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Captain William M. Kendrick, Jr., of Indianapolis, has gone overseas with a station hospital. He was stationed at Fort Lewis, Washington, but now has a San Francisco A.P.O. address.

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A letter of appreciation for THE JOURNAL, and change of address, has come to us from Captain Wendell C. Anderson, of Rockville. Previously with a station hospital, he is now in the surgeon's office at a headquarters base, although he does not say where.

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Lieutenant Colonel Brice E. Fitzgerald, of Indianapolis, has served as wing surgeon for two invasions—the Normandy assault and the airborne landings in southern France. Stationed at a United States troop carrier base, Colonel Fitzgerald has directed the evacuation of more than twenty-eight thousand wounded from the battlefields of France to hospitals in England.

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The Silver Star has been awarded to Captain John H. Kilmer, of Fort Wayne, for heroism during operations in central Italy preceding the D-day landing on the coast of Normandy. Captain Kilmer's battalion had been ordered to go through the enemy lines as a preliminary to a general advance. It paid a terrible price for every yard gained, and the slope over which the battalion advanced was dotted with casualties. It is reported that Captain Kilmer moved among them, personally supervising the First Aid to all wounded men. His battalion commander said: "Captain Kilmer was an inspiration to the men of this battalion. Without doubt he saved many lives during the four days we were going forward. His personal courage and his devotion to duty reflected great credit both upon him as an individual and upon the forces he served."

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During the opening phase of the invasion of the Philippines, a group of Army medical men worked unceasingly throughout a forty-eight-hour crisis, performing two hundred and fifty operations in a two-day period. Among this group was Lieutenant Charles L. George, of Indianapolis, who has been overseas since August, 1943. According to an Associated Press dispatch, the physicians worked under most adverse conditions, five operating tables being crowded into a space which could really accommodate only one, and the surgeons operated under the shadow-streaked rays of an improvised lighting system which gave little more light than an ordinary living room chandelier. Newly-arrived wounded lay in litters on the floor. In spite of these difficulties the doctors averaged one hundred operations daily.

Colonel Harry L. Dale, commanding officer of Billings General Hospital since March 1, 1941, the date it was opened, has received orders to report to the Ninth Service Command Army Service Force Regional Hospital, at Oakland, California, where he will be in command. Colonel Albert E. McEvers, now in charge of the Oakland Hospital, will take command of Billings Hospital.

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In a recent V-mail letter Lieutenant (jg) Joseph R. Eastman, Jr., of Indianapolis, states: "This is to express my thanks for receiving THE JOURNAL and to give you my new address. I enjoyed very much working at the United States Naval Hospital at Shoemaker. The new assignment gives every indication of being more exciting, for you see I'm with the Marine Corps, and aviation at that. Navy doctors practice very good medicine, and our equipment is the best. We even have our own medical meetings out here. So far I haven't run into any Indiana doctors since leaving the States, but there are enough out here that I probably shall."

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Dr. Earl E. Parker, of South Bend, is stationed with a general hospital in the South Pacific. In a letter to the St. Joseph County Medical Society *Bulletin* he wrote: "We have now been in operation almost three months, but our base is so far from activities that our patient list is less than one-third of our minimum strength. Our present status is very uncertain. The past three weeks would almost remind one of California—very little rain; sunshine all day long; cool at night. If it were like this the year around, it really would be ideal. Our ship must have come in, for we have bully beef only six days a week now. Maybe it is because one of my roommates is the mess officer. Those of you who have had the pleasure of making your residence in Indianapolis will be interested to know that Colonel F. E. Keeling has been president of our medical society for the past year. We have some very interesting meetings. Many good lecturers are located in this area. The subjects discussed cover the field quite well."

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In a recent issue the *St. Joseph County Medical Society Bulletin* published "A Medico Reports on the Invasion," which is a most interesting story of the invasion of France, as told in excerpts of letters sent to his wife by Captain George E. Gates, of South Bend:

" 'Well, here I am in France—everything is fine. I feel safe as a bug in a rug—or almost! This is the first chance I've had to write. Could have written sooner, but it wouldn't have been sent. It's uncomfortable writing here, lying on my belly in my pup tent, and my fingers are cold. I'll tell you only what I think will pass the censor.

" 'I think it will soon be over, how soon I don't know—and I have no illusions about the rough times I'll have before then, but I've inquired from the units around here, and the number of doctors lost has been negligible, although a lot of first aid men have gotten it.

" 'The medics of our regiment were the first ones over, and we had to laugh at them using us to "spearhead" the division, and part of them got lost in the blackout, and came very nearly getting into the German lines, but not your Uncle Georgie. The nights are the worst—too much noise with the snipers very active. These French aren't all on our side, and I can't understand that, although I suppose they are angry about seeing France a battleground again. Eating well, although all canned (C) or packaged (D and K) rations, but I have little gasoline heaters, and can heat water, Nescafe or bouillon on it. Still no mail over here, for any of us—the wind has been so strong it has held up the rest of our division.

" 'It's been rather a rough last four days; however, a rest is coming up. War is hell. I never knew it could be so bad, although my part of it is nothing compared to some of the others, especially my aid-men. They are magnificent and I get compliments on all sides for their work.

" 'I've been living the life of Riley since the last letter—although I guess Riley didn't sleep in a foxhole! But at least it's been quiet, and as for my foxhole, one of the officers who saw it said, "That's not a foxhole—that's a home!" And he wasn't far wrong. We have a big trench in a hedge now. We enlarged it, put logs across it, leaves and twigs on that, and then a foot of dirt on top of that. We sleep well except for heavy rainfall, and a little dirt dropping in our eyes off and on through the night. My boys (here) are the toast of the place these days; they've done a wonderful job to date, and they treat us like prima donnas. They should—I spent a lot of time training them, and they're the best bunch in the division.

" 'Got hold of some potatoes and onions out of a garden near here. They tasted very good, because these K rations get very monotonous, and I can't say I'm gaining any weight. Also had a nice bath today, the first I had washed or shaved for a week. The bath was in a round wooden tub beside a pump in a barnyard—a little chilly, but it felt good. I'm hunting for cigars. I got two bottles of cider yesterday for eight francs (16c each). I'm not so bad with my French; they usually understand me if I can find the right phrase. If you complete a major deal, you get a big grin from everyone. Yesterday a French peasant and her daughter came over to our field to milk their cows. They had their cows on a donkey—donkey had a wooden rack over the sides of its saddle. The men were quite curious at the scene, so they snapped pictures, at which the women blushed, pulled their aprons over their faces, and hid behind their cows. The countryside is very pretty, but the towns are in bad shape; they look like Stalingrad in places.

" 'Have had a nice lazy couple of days—or rather almost lazy; they were lazy in comparison, at least, and I wish it could last! I went swimming in a drainage ditch yesterday. It wasn't too bad at first! This part of France is quite pretty, quite pastoral, but as I look around I see many of their cows dead and bloated. There are a few gardens and chickens, which reminds me, onions and potatoes taste awfully good, even if I've had them many times now. I was issued oranges and bread three or four times; otherwise, it's all out of cans or packages, and every day or two I have to send someone back to a dentist to get impressions for a new plate! No kidding, the crackers that go with K rations are a little tough on the dental plates. This whole section of France has been heavily shelled—every building damaged—mostly levelled. We have had to do it as the Germans leave snipers in every church steeple—or every church steeple is an artillery observation post. I've seen three of them myself, so that's no rumor. I have talked to a lot of prisoners, and can't help but feel I'll be home sooner than you think.

" 'Lots of rain here the last few days, and just a sea of mud, tying us down at a bad time, too, as the plum is getting riper, and we'd like to pick it and get this over with! We haven't been here long, but everyone is pretty fed up; it's rough country (hedgerows) to fight in for our tanks.' "

# News Notes

Dr. John A. Mirro, of Lowell, and Lieutenant Cecilia O'Malley, of the Army Nurse Corps, were married recently at the SS. Peter and Paul Church in Hopkinsville, Kentucky, near Camp Campbell, where the bride is on duty at the post hospital.

Dr. George S. Bond and Dr. J. H. Stygall, of Indianapolis, have opened new offices at 1221 North Delaware Street. Their offices are now in the home of the late Samuel Duncan Miller, which has been completely modernized.

It has just come to our attention that Dr. and Mrs. John T. Kime, of Petersburg, observed their Golden Wedding, on October twenty-ninth. Open house was held, and many of their friends called to honor them.

At the annual meeting of the Aesculapian Society of the Wabash Valley, held October twenty-seventh at Paris, Illinois, Dr. J. R. Yung, of Terre Haute, was elected president; Dr. M. C. Topping, of Terre Haute, was elected vice-president; and Dr. E. O. Nay, of Terre Haute, was elected secretary-treasurer.

Dr. Joseph C. Lill, who has practiced medicine in Fort Wayne for the past twenty-five years, has moved to Fort Lauderdale, Florida, where he will continue to practice.

Dr. Kenneth F. Laws, and Miss Betty J. Lahrman, both of Lafayette, were married on November ninth, at the Log Chapel on the campus of Notre Dame University, at South Bend. They will make their home in Lafayette, where Doctor Laws is associated with his father, Dr. Harry J. Laws, in the practice of medicine.

It was announced on December seventh that William P. Garshwiler, M.D., had presented his library to Franklin College, in memory of his wife, Mrs. Florence Province Garshwiler, and her brother, Dr. Clarence Province. Doctor Garshwiler died only a few days later. All three had attended Franklin College.

### FIVE-HUNDRED-DOLLAR AWARD

A five-hundred-dollar award is being offered for the most valuable original paper adding to existing knowledge in the diagnosis of early glaucoma, or the medical treatment of noncongestive glaucoma. Papers may be presented by any practicing ophthalmologist of the Western Hemisphere. This award will take the place of the two separate prizes of two hundred fifty dollars each, which had been announced some time ago. For further information, write to the National Society for the Prevention of Blindness, 1790 Broadway, New York 19, New York.

### MEETING OF THE FIELD ARMY

The Field Army of the American Cancer Society will hold a dinner meeting at the Y.M.C.A., at Anderson, on January twenty-third, at 6:30 P.M. Dr. W. D. Gatch, dean of the Indiana University School of Medicine, will talk on "The Prospect of the Cancer Patient Today." His talk will be illustrated by slides.

### INDIANA ASSOCIATION OF THE HISTORY OF MEDICINE

The nineteenth regular meeting of the Indiana Association of the History of Medicine was held in Parlor E, at the Lincoln Hotel, Indianapolis, on Friday evening, December eighth. Twenty-three members and guests attended this meeting.

Dr. James O. Ritchey, of Indianapolis, presented a paper on "Doctor Books," a subject closely aligned with the history of medicine. Dr. Ritchey has made a very careful study of the more recent books written by doctors themselves, or by others, and found the number and assortment so extant as to practically defy an attempt at classification. However, a somewhat elastic classification was made as follows:

I. Historical.
II. Biographical.
III. Novel.
IV. Personal Experience.
V. Educational Essay.
VI. Philosophical.

In looking for an answer as to why interest in things medical comes to mind, Doctor Ritchey came to the conclusion that Hippocrates might have the answer in part, in one of his proverbs, "Where there is love of man, there is also love of The Art," meaning The Art of Medicine; hence, because man loves man and is interested in his welfare, he would naturally be interested in the art by which these interests were protected. He cited numerous other interesting examples, from the Middle Ages to our present era, pointing out that in olden times medicine was so intimately associated with magic and religion as to be overshadowed by them, and that the story of emergence of medicine from such a bondage is in itself a most absorbing one. Dr. Ritchey examplified his classifications by enumerating many of the more prominent books, showing the pattern of these medical treatises, and quoting some of the basic facts upon which they evolve. Dr. Ritchey concluded his paper by saying, "It might be stated that since the development of medicine throughout the ages *is* an integral part of our civilized idea, any treatise upon such a subject, properly written, is not only useful but of high educational value. Just as medical truths were evolved by extreme self-sacrifice and martyrdom, just so the story is likewise equally interesting. Biographical sketches of the great characters in this drama are of like interest and value. When we

come to the novel as written today, the motives and interests are entirely different. So many of the present-day English novelists are doctors that it would seem that one purpose of the medical school is to educate novelists." Finally, he concluded by directing attention to the first aphorism, ennunciated by the Father of Medicine: "Life is short, and the Art long, the occasion fleeting, experiences fallacious and judgment difficult."

In recognition of the accomplishment of Mrs. Dorothy Russo, our vice-president, whose book entitled "A Bibliography of James Whitcomb Riley" has just been published, and of which we are justly proud, a floral tribute was presented by Dr. Edgar F. Kiser in behalf of the association. Mrs. Russo deserves much credit for having taken up the work in completing this edition, the plan and work for which was largely done by her husband, Mr. Anthony Russo, prior to his death on June 6, 1940.

## INDIANA UNIVERSITY NEWS NOTES

The heaviest of the wartime burdens placed on Indiana University have fallen on its Medical Center, at Indianapolis, but in the opinion of administrative officers there, "the Center has thrived on adversity" and faces the postwar period with confidence.

Since Pearl Harbor the Indiana University Medical Center, made up of five schools and divisions, three hospitals, and numerous clinics, has encountered one difficulty after another. On the one hand have the armed services and governmental agencies been demanding more doctors, more dentists, more nurses, more medical technologists, and more dietitians, and on the other hand there has been a continued depletion of faculty and staff, competition of war industry for personnel, increased enrollment, crowded quarters, mounting hospital admissions, unavailable supplies, and inadequate equipment. Administrative officers of the center joined in the statement: "The battle has been won although the fighting continues."

Training for the armed services is shown in the medical center's war record as only a part of the job. The medical center's hospitals and clinics have provided medical care and treatment for a steadily-increasing number of the state's citizens. In the year ending last June 30, these hospitals cared for 10,739 patients, received 35,309 visits from outpatients, and conducted 134,066 laboratory examinations.

Alumni of the medical center's schools, doctors, dentists, nurses and dietitians are serving on all of the country's far-flung battlefronts. Behind the battlelines the Indiana General Hospital, organized and recruited at the medical center, is in operation and has received the commendation of commanding officers in the European Theater of Operations.

"The medical profession in Japan is not so obstinate in the alleged inherent belief that the Japanese are completely superior," asserts Lieutenant Commander Bernard W. Cohen (who was graduated from the Indiana University School of Medicine in 1936) in a letter from the Pacific War Theater, to Dean W. D. Gatch, presenting to the Indiana University School of Medicine some Japanese medical equipment found on Saipan.

"During the Saipan campaign I visited a small field hospital which had only a short time before been abandoned by the Japanese," said Commander Cohen, who is serving with the Marine Corps. "There I picked up a few things which I thought might be of interest, so I have mailed them to you as a souvenir of the operation.

"The book on surgery impressed me very much. It seems that the Japanese have not restricted their proficiency in photography to the military alone. The illustrations are excellent. The liberal use of Latin and German terminology, the former in English letters, might be interpreted as an indication that the medical profession in Japan is not so obstinate in the alleged belief that the Japanese are completely superior.

"I know very little about dental instruments, but the little kit I enclosed in the package demonstrates very well the ingenious way in which the Japs put up their instruments of all kinds for use in the field. When I first saw the Japanese tourniquet, I thought it to be an excellent device. Since then, however, I have had the opportunity to see several of their cases on which tourniquets were applied, and they simply do not work. Speaking of tourniquets, it is really remarkable how extensive a wound of an extremity, caused by shell or bomb fragments, can be controlled without bleeding. It is my idea that the intense heat of the fragment fries the tissue, including the blood vessels, as it goes along."

### ANNUAL SESSION OF NATIONAL CONFERENCE ON MEDICAL SERVICE

Postwar distribution of medical care will be the theme for the nineteenth annual session of the National Conference on Medical Service, to be held in the Red Lacquer Room of the Palmer House, in Chicago, on Sunday, February 11, 1945.

Medical legislation, physical fitness program, rehabilitation of veterans, latest word from the Washington front, relationship between labor and farm groups and medicine are among the topics to be discussed by nationally-known speakers who will appear on the program. Also listed on the program will be an open discussion on prepayment medical plans, the principal advantages and defects of both service and indemnity types of insurance being presented.

All members of the American Medical Association are invited to attend.

Detailed programs of the conference may be obtained by writing Cleon A. Nafe, M.D., secretary, National Conference on Medical Service, 822 Hume Mansur Building, Indianapolis 4, Indiana.

# POSTWAR HAPPENINGS TWENTY-FIVE YEARS AGO

(Items from THE JOURNAL of January, 1920)

The official family for the new year was:
President, Charles H. McCully, Logansport.
First Vice-President, Budd Van Sweringen, Fort Wayne.
Second Vice-President, Samuel Hollis, Hartford City.
Third Vice-President, Charles Stoltz, South Bend.
Secretary-Treasurer, Charles N. Combs, Terre Haute.
Executive Secretary, Frederick E. Schortemeier.
Acting Executive Secretary, F. E. Raschig, now of the Editorial Department of the *Indianapolis Star*.
G. W. H. Kemper, Muncie, was chairman of the Council. (Doctor Kemper was then eighty years old.)

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"The Value of the Roentgen Ray in the Diagnostic Work of the Internist," by G. W. McCaskey, of Fort Wayne; "Some Fractures of the Pelvis," by Charles Haywood, of Elkhart; "The Relative Merits of Surgery, Radium and Roentgen Ray in the Treatment of Uterine Fibroids," by E. E. Padgett, of Indianapolis; and "Conservative Surgery," by O. O. Melton, of Hammond, comprised the scientific section.

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The editor discussed Public Health, Medical Law Violations, Indiana Doctors in the Late War, the Death of Sir William Osler, and JOURNAL Advertising.

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Several hundred deaths and many cases of blindness had been reported as having resulted from the consumption of wood alcohol. (These were Prohibition times, you know.)

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Doctors were advised to be chary about investing in "oil stocks," with which the country was being flooded at that time.

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"The Miracle Man," then holding forth at New Carlisle, Indiana, was reported as having produced some miraculous cures. The editor stated that the wife of a South Bend nationally-known manufacturer had reported that his "touch" had completely cured her. The editor naively cites the fact that the "touch" probably meant the extraction of a sizeable fee from the patient.

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A bill for compulsory health insurance had been introduced into the New York State Legislature. The measure was said to have the support of the New York State Federation of Labor.

A physicians telephone exchange, now found in most of our larger cities, was being installed in one of our cities.

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A Fort Wayne chiropractor was advertising that he had served in the recent war as a chiropractor, in connection with the Medical Department of the Army, and that at the close of the war he was sent, at government expense, to perfect himself in "chiropractic spinagraphy and spinal roentgen-ray." Investigation showed that there was not one iota of truth in his declarations.

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A Munich, Germany, newspaper had printed an article in which it was claimed that American chemical and dye manufacturers were offering "big shot" German chemists fabulous salaries to come to this country and take over their chemical laboratories; that American chemicals, such as various dyes and salvarsan, were not as good as those made in Germany.

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Wabash County was to have a new hospital, bids for same to be opened January 21, 1920.

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Doctors still were returning from service, among them being Ralph Arnold, of Greenfield; J. C. Ross, of Marion; E. A. Willis, of Indianapolis; E. H. Pea, of Vincennes; A. E. Mozingo, of Indianapolis, and E. N. Kime, of Indianapolis.

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A committee of five had been appointed by the Shelby County Medical Society to investigate the prospects for a county hospital.

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Dr. Burton D. Myers, of Bloomington, had undergone an operation for gallstones.

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Over one thousand cans of fruit and jellies had been donated to the Goshen Hospital, on "Hospital Donation Day."

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Marshall County physicians announced a new fee bill, all fees having been increased.

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Princeton physicians had decided that they wanted a little more time with their families, and to do a bit of studying, so had announced that their offices would close at 5:30 P.M. Patients wishing to see them after that time would have to make an appointment.

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The Sisters of St. Francis, of Perpetual Adoration, were planning a new addition to their hospital in Terre Haute.

# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION

### THE COUNCIL

**Special Meeting, Indianapolis**

*December 10, 1944*

The Council of the Indiana State Medical Association convened in executive session in the Harrison Room of the Columbia Club, Indianapolis, on Sunday, December 10, for a special meeting, called to consider appointments to the insurance committee which was authorized by the House of Delegates at its special meeting on November 12. The meeting was called to order at 2:15 P.M. by Dr. Floyd T. Romberger, chairman. The following were present:

*Members of the Council:*

First District—I. C. Barclay, Evansville
Second District—H. C. Wadsworth, Washington
Third District—A. P. Hauss, New Albany
Fourth District—J. C. Elliott, Guilford
Charles F. Overpeck, Greensburg, councilor-elect
Fifth District—A. M. Mitchell, Terre Haute
Sixth District—W. U. Kennedy, New Castle
Seventh District—W. L. Portteus, Franklin
Eighth District—E. H. Clauser, Muncie
Ninth District—F. T. Romberger, Lafayette
Eleventh District—C. S. Black, Warren

*Officers:*

J. T. Oliphant, Farmersburg, president
N. K. Forster, Hammond, president-elect 1944
J. E. Ferrell, Fortville, president-elect 1945
A. F. Weyerbacher, Indianapolis, treasurer
C. A. Nafe, Indianapolis, chairman, Executive Committee
C. H. McCaskey, Indianapolis, Executive Committee
Albert Stump, Indianapolis, attorney
T. A. Hendricks, executive secretary

Dr. Oliphant made a preliminary statement in which he said that both he and Dr. Forster had determined upon the policy for making up this committee, and desired the suggestions and the help of the Council. He said that he felt the committee should be a large one and representative of the entire state and the various fields of medical practice.

The chairman then called upon each councilor to suggest names from his district for membership on this committee. The following suggestions were received:

*First District:*

Robert Acre, Evansville, urology
A. W. Ratcliffe, Evansville, clinical pathology
George Willison, Evansville, internal medicine
O. T. Brazelton, Princeton, surgery

*Second District:*

C. Philip Fox, Washington, surgery
Julia Thom, Spencer, general practice and ophthalmology
James B. Maple, Sullivan, general practice and obstetrics

*Third District:*

Claude Dollens, Oolitic, general practice and obstetrics
J. Y. McCullough, New Albany, surgery
William E. Amy, Corydon, general practice
Claude B. Paynter, Salem, general practice
E. P. Buckley, Jeffersonville, anesthesiology

*Fourth District:*

I. M. Sanders, Greensburg, general practice
George S. Row, Osgood, general practice and surgery
Captain George A. May, Madison, general practice
Marvin R. Davis, Columbus, general practice
G. S. Fessler, Rising Sun, general practice
Charles E. Gillespie, Seymour, ophthalmology, otology, laryngology, and rhinology.

*Fifth District:*

M. C. Topping, Terre Haute, orthopedic surgery
O. O. Alexander, Terre Haute, surgery

*Sixth District:*

Joseph L. Allen, Greenfield, general practice
W. D. Inlow, Shelbyville, surgery
L. C. Marshall, Mt. Summit, general practice

*Seventh District:*

O. T. Scamahorn, Pittsboro, general practice and pediatrics
M. C. Pitkin, Martinsville, internal medicine
Marlow W. Manion, Indianapolis, otology, laryngology, rhinology
Ben B. Moore, Indianapolis, surgery
Walter P. Morton, Indianapolis, urology
Lyman T. Meiks, Indianapolis, pediatrics
Roy V. Myers, Indianapolis, general practice
Harry L. Foreman, Indianapolis, internal medicine

*Eighth District:*

Clay A. Ball, Muncie, general practice
Henry Bibler, Muncie, general practice
Henry W. Gante, Anderson, pediatrics
W. M. Miley, Anderson, internal medicine
George V. Cring, Portland, internal medicine

*Ninth District:*

Wemple Dodds, Crawfordsville, roentgenology and radiology
George A. Collett, Crawfordsville, surgery
Gordon A. Thomas, Lafayette, general practice
Earl Van Reed, Lafayette, general practice
F. S. Crockeett, Lafayette, urology

*Eleventh District:*

G. M. Nie, Huntington, general practice
E. R. Clarke, Kokomo, pediatrics

Letters were to be written to those councilors who were not present, asking for their suggestions. It was agreed that councilors would be available to serve on this committee if the president and president-elect so desire. (The committee is to be made up from these suggestions, and will be announced later.)

Dr. Hauss suggested that a representative of the American Medical Association be called in to sit with this committee when it meets. The chairman referred this suggestion to the president and the new committee.

### Allen County Membership Problem

The chairman announced that Dr. Sparks, councilor of the Twelfth District, had telephoned saying that a blizzard had forced him to turn back, and that he would be unable to attend the meeting. Dr. Sparks asked that the chairman present to the Council, for advice and information, a membership problem which confronts the Fort Wayne (Allen County) Medical Society. Some time ago the Fort Wayne Society passed a resolution to the effect that no new members would be admitted to the society during the war. Dr. Sparks asked for information as to what other societies had done in this respect. It was the consensus of opinion of the Council that this is a local problem, and that Dr. Sparks should be referred to Section 4, Chapter X, of the By-Laws, which states that "Each county society shall be judge of the qualifications of its own members."

### Request from A.M.A.

Request made that Thomas A. Hendricks, executive secretary of the Indiana State Medical Association, help out part time on the new Council on Medical Service and Public Relations of the American Medical Association. The Council was of the opinion that this is a compliment to the Indiana State Medical Association, and after discussion approved of Tom Hendricks helping out the new Council of the American Medical Association. Upon the motion of Dr. Wadsworth, seconded by Dr. Mitchell, details of this arrangement were delegated to the Executive Committee and the executive secretary.

There being no further business, the meeting was adjourned.

THOMAS A. HENDRICKS,
*Executive Secretary.*

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Suggestions received since the Council meeting:

*Thirteenth District:*

F. R. N. Carter, South Bend, urology and general practice
R. B. Sanderson, South Bend, tuberculosis
J. W. Hilbert, South Bend, industrial practice
Sam Miller, Elkhart, surgery and general practice
L. W. Vore, Plymouth, general practice
G. O. Larson, LaPorte, general practice

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After February 1, 1945, your county and state medical society dues are delinquent. Are you one of the laggers? Get in line immediately by handing your check to your county medical society secretary.

## INDIANA STATE MEDICAL ASSOCIATION

### EXECUTIVE COMMITTEE

November 11, 1944.

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; J. T. Oliphant, M.D.; N. K. Forster, M.D.; F. T. Romberger, M.D.; E. M. Shanklin, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney; F. S. Crockett, M.D.; R. L. Sensenich, M.D.; and T. A. Hendricks, executive secretary.

### Membership Report

| | |
|---|---|
| Number of members November 11, 1944 | 3,385* |
| Number of members November 11, 1943 | 3,335 |
| Gain over last year | 50 |

* Includes 964 in military service and 126 honorary members.

### Treasurer's Office

The committee approved the annual audit of the books by George S. Olive and Company.

The transfer, as a loan, from the Medical Defense Fund of $3,000 to THE JOURNAL Fund, and $1,500 to the Association's General Fund, was approved upon the motion of Dr. Forster, seconded by Dr. McCaskey.

*Special Meeting of the House of Delegates*

### November 12, 1944

Dr. Oliphant suggested a method of procedure for the special meeting of the House of Delegates.

The committee approved having a representative from the Red Cross speak in regard to the need for nurses, upon unanimous consent of the House.

Announcement made that Dr. A. S. Brunk, president of the Michigan State Medical Society, had been invited by Dr. Howard's committee to attend the special meeting of the House of Delegates.

The statements of receipts and expenditures for October, for the association committees and THE JOURNAL, were approved.

### 1945 Annual Session, French Lick, Tuesday, Wednesday, and Thursday, October 2, 3, and 4, 1945

Upon the motion of Dr. Forster, seconded by Dr. McCaskey, the committee approved the dates of October 2, 3, and 4 for the meeting.

### Legislative, Legal, and Social Security Matters

*National*

Both Representative Dingell and Senator Wagner were re-elected.

Many of the leaders of the Committee of 430 are reorganized in a special group, called "The Health Program Conference."

Dr. Forster reported that a group of industrialists are opposed to socialized medicine, and will be willing to use a slogan against socialized medicine on their letterheads if this is supplied to them. The secretary was instructed to think up such a slogan.

*Local*

A bulletin in regard to the new medical registration and examination measure, and the amend-

ment to the hospital law, is to be sent throughout the state by the Legislative Committee. Both of these measures have been approved by the House of Delegates.

Announcement by the Social Workers' group that it supports the new State Board of Health legislation received by the committee.

#### Prepayment Medical Plans

The actions of the Ohio and the Iowa State Medical Societies, in approving prepayment medical plans, brought to the attention of the committee. Ohio has approved the formation of a cash indemnity stock company, while Iowa has approved a medical service plan similar to the Michigan plan.

A statement by Dr. Robert E. S. Young, of Ohio, in regard to insurance, was brought to the attention of the committee.

Folder upon "Michigan Medical Service," by John G. Baker, condensed from an article in the *Milwaukee Journal*, given to members of the committee.

Actions by the following county medical societies in regard to a prepayment plan brought to the attention of the committee: Noble, Miami, Elkhart, St. Joseph, Allen, Montgomery, and Marion.

The LaGuardia Plan, United Medical Service, brought to the attention of the committee.

Dr. A. Jerome Sparks and Dr. W. L. Portteus visited Michigan Medical Service as representatives of the Indiana State Medical Association.

#### Organization Matters

Upon the motion of Dr. Oliphant, seconded by Dr. McCaskey, it was voted to remit the dues of a physician who is serving in the Coast Guard as a member on active duty with the armed forces.

Report made by Dr. Forster upon the regional conference of the Council on Medical Service and Public Relations of the American Medical Association, held at Cincinnati, October 22. Eighteen Indiana men attended this conference.

*Payment of back dues to state medical association.* If the local county societies send in back dues, the state association is to accept them.

#### Medical Economics

Dr. Nafe is to report at the next meeting upon the understanding between the American Red Cross and the University hospitals in regard to cases involving servicemen's families.

*Advertising in labor papers.* Letter received from Walter Frisbie, secretary-treasurer of the Indiana State Industrial Union Council of the CIO, informing the state association that the CIO has only one official publication, the annual year book. The letter continues:

> "The solicitor carries proper credentials. Our organization sponsors no newspapers or other periodicals.
>
> "Certain of the local councils sponsor weekly newspapers. These, however, are not important and are usually not doing general soliciting work. They include the *Tri County News* from South Bend and the *Labor Journal* from Anderson."

#### War and Postwar Medicine

The committee discussed some of the problems of war and postwar medicine, among them Ohio River sanitation, which Dr. Forster said was brought up at the regional conference at Cincinnati, and the "setup" after the war in regard to graduate and postgraduate teaching.

#### Socialized Medicine

The so-called "little Wagner-Murray-Dingell bill" is up for consideration in the state of Michigan.

Dr. Forster presented a letter advocating socialized medicine, from an Indiana resident, and also his reply to this letter. Dr. Forster said, "We have to come out of our shell and meet these people face to face, in conferences, dinners, meetings, or any other way. Maybe we can't change their opinions, but we can at least soften the radical measures they may have in mind."

*Pepper Committee hearings.* Two booklets are to be obtained for members of the committee upon the hearings of the Senate Subcommittee on Wartime Health and Education (the Pepper Committee).

#### Cult Practice

*Kaadt diabetic cure.* Many requests for information in regard to this cure are received at the headquarters office of the Indiana State Medical Association. The American Medical Association made an investigation some time ago in regard to Dr. Kaadt's treatment. Dr. Kaadt is not a member in good standing of the Indiana State Medical Association. This information is forwarded to those making inquiry. Apparently the promotion of the Kaadt diabetic treatment extends to all parts of the country, as letters are received from almost every state.

#### Future Meetings

November 16, 1944—EMIC meeting, Chicago.

November 17-18, 1944—Secretaries' Conference, A.M.A.

November 13-15, 1944—Conference on Social Work. Clyde White and Albert Stump to speak on Wagner-Murray-Dingell Bill, Wednesday, November 15, 10:45 A.M., Assembly Room, Claypool Hotel.

December 3-4, 1944—Meeting of insurance company representatives, under direction of National Physicians' Committee, New York.

Representatives of the state medical association are to attend these meetings.

#### State Board of Health

*Postwar program.* The difference in the wording in the October Bulletin of the Indiana State Board of Health, on the postwar health program for the State Board of Health, and in the report adopted by the House of Delegates concerning this program brought to the attention of the committee. The difference in wording concerns the matter of the use of federal funds. In the State Board of Health Bulletin for October the wording is as follows:

"The county commissioners should have the power to set up such districts. The expenses of such a district should be paid locally when that is possible. When unable to pay all expenses of such an undertaking, the community itself should be able to ask for and get State funds to supplement its own funds, the amount of such outside help to be determined by the exigencies of the situation, as determined by careful study. *The district should be under local control insofar as that is possible, but should, of course, cooperate with State agencies and should welcome such cooperation at the State level.* If State funds are accepted, it will be necessary, of course, to submit to audit at that level."

In the House of Delegates' report the wording is as follows:

"The county commissioners should have the power to set up such districts. The expenses of such a district shall be paid locally when that is possible. When unable to pay all expenses of such an undertaking, the community itself should be able to ask for and get state funds to supplement its own funds, the amount of such outside help to be determined by careful study. *The district should be under local control, but should, of course, cooperate insofar as possible with state agencies.* If state funds are accepted, it will be necessary, of course, to submit to audit at that level."

### The Journal

Letter from Elton J. Buckley, attorney, of Philadelphia, concerning articles on commercial law brought to the attention of the committee. A letter is to be written to Mr. Buckley, thanking him, and stating that because of the paper shortage THE JOURNAL cannot use these articles at this time.

The committee approved the publication of the letter from Mary Krish, state president of the Indiana State Society of X-ray Technicians, if it meets the approval of the head of the Indiana Roentgen Ray Society.

Letter received from Colonel Walter S. Jensen, M.C., Air Surgeon of the Army Air Forces, expressing appreciation for the invitation to the state meeting, and commendation for the convention (Army Air Force) number of THE JOURNAL.

Letter received from F. E. Young and Company asking the state association to carry its advertisements. The members of the committee felt that it was all right to take these advertisements again.

### Medical Defense

*Group insurance*

(a) Report made that three hundred physicians are now signed up with the St. Paul Mercury Indemnity Company.

(b) Report made that a national medical group may take out a group policy for sixteen hundred of its members as a result of the Indiana State Medical Association taking out group defense.

(c) Dr. Nafe reported the experience of the Connecticut State Medical Association's doctors in the reduction of fees, as a result of having a group policy. He hopes that experience will show that a similar reduction may be made here in Indiana.

(d) Letters from various physicians in regard to changing their medical defense insurance to the St. Paul Mercury Indemnity Company brought to the attention of the committee. No physician is obligated under the arrangements with the St. Paul Mercury Indemnity Company to change his insurance to that company. However, the committee hopes that a sufficient number of physicians will take out insurance with the St. Paul Mercury Indemnity Company in order that medical defense experience will be obtained whereby the costs of medical defense may be lowered in the future.

(e) Jay County Medical Society physicians report that the cost of insurance with the St. Paul Mercury Indemnity Company is higher than insurance with other companies. A check is to be made with Morris Crain, state agent for the St. Paul Mercury Indemnity Company, to see if the coverage given by other companies is comparable to that given by the St. Paul Mercury Indemnity Company.

There being no further business the meeting was adjourned.

## LOCAL SOCIETY REPORTS

### 100% IN PAYMENT OF 1945 DUES

GIBSON COUNTY

### COUNTY MEDICAL SOCIETY OFFICERS

**HUNTINGTON COUNTY MEDICAL SOCIETY**
President, H. F. Bonifield, Warren
Vice-President, R. S. Galbreath, Huntington
Secretary-treasurer, G. M. Nie, Huntington

**JOHNSON COUNTY MEDICAL SOCIETY**
President, R. C. Wilson, Franklin
Vice-president, Charles Woodcock, Greenwood
Secretary-treasurer, J. H. Machledt, Whiteland

**RANDOLPH COUNTY MEDICAL SOCIETY:**
President, S. K. Phipps, Union City
Vice-president, Byron Nixon, Farmland
Secretary-treasurer, Wayne Harmon, Lynn

**SWITZERLAND COUNTY MEDICAL SOCIETY**
President, G. W. Copeland, Vevay
Vice-president, Fred C. Bakes, Vevay
Secretary-treasurer, L. H. Bear, Vevay

**WABASH COUNTY MEDICAL SOCIETY**
President, Edgar K. Black, Wabash
Vice-president, James G. Kidd, Roann
Secretary-treasurer, J. T. Steffen, Wabash

**Adams County Medical Society** members held a meeting at Decatur on November twenty-first. The speaker was Dr. Samuel R. Mercer, of Fort Wayne, who discussed "Penicillin in the Treatment of Syphilis." Ten members attended the meeting.

*(Continued on page xxv)*

*(Continued from page 32)*

**Cass County Medical Society** members met at the Cass County Hospital on November seventeenth. The speaker was Dr. B. W. Egan, of Logansport, who reported concerning the House of Delegates meeting, on the prepayment insurance plan.

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**Delaware-Blackford County Medical Society** members met at the Roberts Hotel, in Muncie, on November twenty-first. Twenty-five members were present. Officers were elected for the ensuing year, and the members discussed the health insurance project of the state association.

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**Elkhart County Medical Society** members met on December seventh at the Hotel Elkhart, this being the annual meeting for election of officers. Dr. Lloyd R. Studebaker, of New Paris, told of his experiences as a medical missionary in Nigeria, West Africa. Thirty-two members attended the meeting.

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**Fort Wayne County Medical Society** members held a meeting on November twenty-first at the St. Joseph Hospital Nurses' Home. The speaker was Dr. L. T. Meiks, of Indianapolis, who discussed "Obstructive Dyspnea in Children." The talk was illustrated by lantern slides. Thirty members were present.

On November twenty-eighth another meeting was held at the Chamber of Commerce for the discussion of current business. Twenty-five members were in attendance.

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**Hancock County Medical Society** members met at the Cozy Hotel, near Greenfield, on December thirteenth. Dr. J. E. Ferrell, of Fortville, was in charge of the meeting. Current items of importance were discussed. Officers were also elected for 1945.

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**Howard County Medical Society** members held a meeting at the St. Joseph Memorial Hospital on November third. Officers were elected for the following year.

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**Hendricks County Medical Society** members met at the City Restaurant on November third for their regular luncheon meeting. Insurance problems were discussed.

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**Kosciusko County Medical Society** members met at the cottage of Dr. T. S. Schuldt (of Pierceton) at Riley Beach, Ridinger Lake, on October twenty-seventh. The speaker for this dinner meeting was Dr. W. F. Gessler, of Fort Wayne.

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**St. Joseph County Medical Society** members met at the Indiana Club, at South Bend, on November twenty-second, to hear Dr. George L. Apfelbach, of Chicago, who discussed "Practical Points on Fractures." Forty-five members and guests attended the meeting.


PROFESSIONAL PROTECTION

*DOCTORS DISCHARGED*

from Military Service should notify Company immediately.

*MILITARY POLICY*

does not cover Civilian Practice.

THE MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

COOK COUNTY
GRADUATE SCHOOL OF MEDICINE

(In affiliation with COOK COUNTY HOSPITAL)
Incorporated not for profit

ANNOUNCES CONTINUOUS COURSES

SURGERY—Two Weeks Intensive Course in Surgical Technique starting January 15, 1945, and every two weeks during the year.

GYNECOLOGY—Two Weeks Intensive Course starting February 26, 1945.

OBSTETRICS—Two Weeks Intensive Course starting February 12, 1945.

ANESTHESIA—Two Weeks Course Regional, Intravenous & Caudal Anesthesia.

ROENTGENOLOGY—Courses in X-Ray Interpretation, Fluoroscopy, Deep X-Ray Therapy every week.

UROLOGY—Two Weeks Course and One Month Course available every two weeks.

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GENERAL, INTENSIVE AND SPECIAL COURSES IN ALL BRANCHES OF MEDICINE, SURGERY AND THE SPECIALTIES.

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL.

Address: Registrar, 427 South Honore Street
Chicago 12, Illinois

**Tippecanoe County Medical Society** members held a meeting at the Lincoln Lodge, in Lafayette, on November fourteenth. Dr. Franklin B. Peck, of Indianapolis, presented "Tailor Insulin in Diabetes," which was followed by discussion by the thirty members who attended the meeting.

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**Wabash County Medical Society** members held a meeting at the Sheller Hotel, in North Manchester, on December sixth. This meeting was held for the election of officers and committee reports. Fourteen members were present.

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**Wells County Medical Society** members entertained six medical officers from Baer Field at a meeting held at the Caylor-Nickel Clinic, at Bluffton, on November twentieth. The speaker, Major Hamlin Mattson, of Wakeman General Hospital, discussed "The Use of Superior Pubic Ligament and Rectus Fascia in Hernia Repair," and also showed a movie on "Fascia Transplants." Nineteen members and guests attended the meeting.

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# Books

## BOOKS RECEIVED

**CONTROL OF PAIN IN CHILDBIRTH.** By Clifford B. Lull, M.D., Clinical Professor of Obstetrics, Jefferson Medical College; and Robert A. Hingson, M.D., Surgeon, U. S. Public Health Service, and Director, Post-graduate Medical Course, Philadelphia Lying-In Unit, Pennsylvania Hospital. 356 pages with 132 illustrations, including 32 in color. Price $7.50. Cloth. J. B. Lippincott Company, Philadelphia, 1944.

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**LEAD POISONING.** By Abraham Cantarow, M.D., Associate Professor of Medicine, Jefferson Medical College, Philadelphia, Pennsylvania; and Max Trumper, Ph.D., Lieutenant Commander, H-V (S) USNR, Naval Medical Research Institute, Bethesda, Maryland—formerly Lecturer in Toxicology, Jefferson Medical College, Philadelphia, Pennsylvania. 264 pages. Price $3.00. Cloth. The Williams & Wilkins Company, Baltimore, 1944.

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**INTERNS HANDBOOK.** By members of the Faculty of the College of Medicine, Syracuse University, under the direction of M. S. Dooley, M.D., Professor of Pharmacology; and Maynard E. Holmes, M.D., Professor of Clinical Medicine. 579 pages. Price $3.00. Fabrikoid. J. B. Lippincott Company, Philadelphia, 1944.

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**THE 1944 YEAR BOOK OF GENERAL MEDICINE.** Edited by George F. Dick, M.D., J. Burns Amberson, M.D., George R. Minot, M.D., William B. Castle, M.D., William D. Stroud, M.D., and George B. Eusterman, M.D. 768 pages with 139 illustrations. Price $3.00. Fabrikoid. The Year Book Publishers, Chicago, 1944.

## BOOKS RECEIVED

**A TEXTBOOK ON PATHOLOGY OF LABOR, THE PUERPERIUM AND THE NEWBORN.** By Charles O. McCormick, M.D., Clinical Professor of Obstetrics, Indiana University School of Medicine. 399 pages with 191 illustrations, including 10 in color. Cloth. Price $7.50. C. V. Mosby Company, St. Louis, 1944.

This is a textbook on obstetrics which has recently appeared on the market, under the title of *Pathology of Labor, the Puerperium and the Newborn*, and is really "something different."

In accordance with present-day practice, the author has condensed the subject, eliminating all nonessential verbiage but without sacrificing detail of procedure. Thus, while the book is in synopsis form, it is much more inclusive than the word synopsis would suggest.

Rational sequence of subject matter, concise and complete presentation, illustrated by well-selected and clear drawings, and inclusion of recent developments attune the book to the demands of the day. In his preface the author states, "The concise and direct style of presentation and the comprehensive scope covering the minor and major complications of labor, the puerperium, and the newborn render the book suitable to general practice." I would say "commend" the book to all practitioners of obstetrics.

This is the first textbook on obstetrics to be published by a member of the faculty of the Indiana University School of Medicine, and the book brings credit not only to the author but to the entire faculty of the school. Those of us who know "Mac" (as we affectionately call him) intimately not only glory in his boundless energy and initiative, but congratulate and respect him upon the manner in which he invests same.

H. F. BECKMAN, M.D.

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## INDIANA STATE BOARD OF HEALTH

### DIVISION OF COMMUNICABLE DISEASE CONTROL

### Monthly Report—November, 1944

| *DISEASE* | *Nov. 1944* | *Oct. 1944* | *Sept. 1944* | *Nov. 1943* | *Nov. 1942* |
|---|---|---|---|---|---|
| Chickenpox | 278 | 90 | 35 | 314 | 292 |
| Measles | 19 | 13 | 9 | 407 | 74 |
| Scarlet Fever | 266 | 137 | 100 | 265 | 189 |
| Smallpox | 3 | 2 | 3 | 9 | 8 |
| Typhoid Fever | 6 | 11 | 13 | 2 | 4 |
| Whooping Cough | 44 | 42 | 52 | 111 | 104 |
| Diphtheria | 32 | 40 | 35 | 67 | 30 |
| Influenza | 19 | 9 | 14 | 65 | 48 |
| Pneumonia | 4 | 10 | 6 | 26 | 96 |
| Mumps | 56 | 18 | 22 | 115 | 131 |
| Poliomyelitis | 15 | 37 | 108 | 2 | 8 |
| Cerebrospinal Meningitis | 14 | 12 | 5 | 13 | 2 |
| Nonepidemic Meningitis | 4 | 0 | 1 | 0 | 0 |
| Trachoma | 1 | 3 | 4 | 1 | 0 |
| Tularemia | 1 | 1 | 1 | 2 | 3 |
| Undulant Fever | 7 | 4 | 2 | 5 | 1 |
| Encephalitis | 1 | 1 | 0 | 2 | 0 |
| Rubella | 2 | 0 | 2 | 8 | 5 |
| Malaria | 1 | 2 | 5 | 3 | 0 |
| Impetigo | 2 | 4 | 0 | 0 | 0 |
| Tuberculosis, Pulmonary | 264 | 327 | 264 | 128 | 74 |
| Tuberculosis, Other Forms | 9 | 15 | 9 | 40 | 13 |

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### BOARD MEETING

Mrs. F. M. Gastineau, of Indianapolis, president of the Woman's Auxiliary to the Indiana State Medical Association, presided at the board meeting held November twenty-fifth at the Columbia Club, in Indianapolis. There were thirty board members present, including twelve county presidents.

The meeting was opened at 10:30 A.M. by the reading the Pledge of Loyalty to the A.M.A.

The treasurer, Mrs. A. W. Ratcliffe, said that all dues from the counties must be in to her by March fifteenth.

Mrs. Gastineau reported on the President's Conference, which was held November fifteenth and sixteenth, in Chicago. A complete report of this may be read in the January Bulletin. The plans for the year were outlined. She stressed the importance of the sale of *Hygeia* and recommended that it be placed in public places. She suggested that each county have a Physical Fitness chairman. Mrs. Duemling, national organization chairman of this district, recommended that the State of Indiana be divided into four districts. The four vice-presidents are to take charge of organizing the counties in their own district. Kits were sent to all vice-presidents, giving suggestions helpful to them concerning organization, she stated. It was urged that the wives of all members of the Indiana State Medical Association become members of the State Auxiliary—being called members-at-large—in the event their home counties are not organized.

Mrs. Bakemeier, *Hygeia* chairman, called attention to the fact that *Hygeia* magazine is stressing the Physical Fitness Program now being sponsored by the A.M.A., and said that auxiliary members should read these articles to acquaint themselves with this program. The *Hygeia* quota of each auxiliary is the number of paid-up members each auxiliary had last year.

The legislative chairman, Mrs. F. B. Wishard, asked that each county president appoint a legislative chairman

who might be available at the time the House of Representatives meets. She pointed out that the presence of interested people at the time of debate of bills is more impressive than letters, although the latter is important. Know your representatives! "Information in regard to new legislation will be sent to all chairmen. Go over this with your auxiliary. Let us concern ourselves with our own assembly," she concluded.

Mrs. E. N. Mendenhall thanked the members for their cooperation this year, in sending her the names of all county presidents and vice-presidents. Following are some of the important points in her program outline for the state this year:

1. Adult health education.
   a. Production and sale of Grade A milk.
   b. Sewage disposal and water supply.
   c. Trailer camp sanitation laws.
   d. Food handlers.
2. Emergency legislation.
   a. Emergency Infant and Mother Care Bill—study.
   b. Wagner-Murray-Dingell Bill not to be overlooked.
3. Public relations.
   a. One means of fighting juvenile delinquency.
   b. Rehabilitation of soldiers.
4. Postwar planning.
   Care of aged who are indigent, but who have no place to stay.
5. Social meetings.
   Films, et cetera.

The public relations chairman, Mrs. J. W. Mather, read the National chairman's (Mrs. Spotts') outline for public relations programs. It was recommended that each county have a Health Day Institute. This would be open to the general public, and would be a means of placing material and information in other groups. She called attention to the fact that the State Board of Health has sound pictures which may be procured.

Mrs. U. V. Poland has compiled a very interesting history of our state organization—also data on Pioneer Doctors. Mrs. Harry Foreman, our new Historian, said she would endeavor to keep on with this compilation. Anyone having interesting data on pioneer medicine is to send the report to her.

The county presidents outlined their programs for the coming year. Most of the counties are following the recommendations of our program chairman.

Under the old business, the motion was made and carried that one hundred dollars be allowed annually for expenses incurred at the general assembly of our organization.

There was a great deal of discussion on new business before the Board. The following points were agreed upon:

1. The House of Delegates will meet April 24-25, in Indianapolis.
2. The next board meeting will be held on the evening of April 24.
3. The House of Delegates will convene at 10:00 A.M. on April 25. Luncheon will be served. All business of the state organization will be conducted at this time.
4. The fall meeting, or general assembly, will convene at French Lick October 3-4. This will be an interesting meeting for all members.

Mrs. Gastineau recommended that all county elections of officers take place at the same time as the state election, that is, in the spring at the time of the meeeting of the House of Delegates.

## ALLEN COUNTY

Mrs. James L. Wyatt, Sr., was hostess to the Woman's Auxiliary to the Allen County Medical Society on Tuesday night, November 14, at her home. Dr. Paul P. Bailey, county health commissioner, was the guest speaker, his subject being "Effects of Juvenile Delinquency." Walter H. Nagel, boys' probation officer, reviewed some of the more recent cases he has handled. Another feature of the evening was the showing of Dr. Ernest Carlo's colored photographs, which won second prize in the annual American physicians' showing in Chicago.

Personal items: Mrs. Edward H. Schlegel, a member of the Allen County Auxiliary, was honored by a picture and write-up in the Fort Wayne *News-Sentinel,* in October. Because of her unusual ability as an expert mathematician, she is chairman of innumerable committees of many projects, drives, and parties. A great deal of her work in the universities was in mathematics, and following her graduation all the positions she held pertained to computing figures.

Mrs. N. J. Prentiss, the president of the Allen county group, is director of the Violet Reinwald School of Dancing, which presented a check for $366.79 to the Baer Field post hospital as the proceeds of a show presented last June by the school for the benefit of the hospital fund for convalescent soldiers.

## DELAWARE-BLACKFORD

On December 19 Mrs. U. G. Poland entertained the members of the Delaware-Blackford County Auxiliary with a luncheon at her home in Muncie.

## HOWARD COUNTY

Mrs. F. S. Cuthbert entertained fourteen members of the auxiliary in her home on the evening of November third. The delegates to the state meeting gave their reports, and there was also a report of the tea given by the auxiliary for wives of doctors in attendance at the eleventh Councilor District meeting in Kokomo, October twenty-fifth. The educational meeting was in the charge of Miss Lucy Schuler, program chairman, and was given by Mrs. Elton R. Clarke and Mrs. R. Craig on the proposed prepayment health insurance plans which may be offered to the state legislature at its next meeting.

## LAKE COUNTY

The evening of October thirty-first Dr. and Mrs. L. E. Dupes, of Hobart, entertained the members of the South Branch of the Lake County Medical Auxiliary in their home.

Mrs. H. M. Baitinger described the work being done at the hospital for wounded veterans at Camp Atterbury, Indiana. She explained the purpose of the camp and hospital council service which operates under the Red Cross. This is the newest Red Cross committee and one that will extend during the postwar period, she said.

After hearing the activities and problems of the wounded veterans, the auxiliary voted to have each member bring a box of new Christmas cards to the November 28 meeting. The cards will be sent to the hospital for the servicemen to send greetings to their friends and relatives.

## MARION COUNTY

The Woman's Auxiliary to the Marion County Medical Society met November 22, at 2:00 P.M., in the L. S. Ayres Auditorium, for a fashion clinic and tea. Mrs. Harold M. Trusler, membership chairman, was in charge. Mrs. Henry S. Leonard is president.

An invitation to attend the tea was extended to any wife, mother, or sister of a physician eligible for membership.

## ST. JOSEPH COUNTY

Mrs. R. B. Acker, of South Bend, entertained the members of the St. Joseph County Medical Auxiliary on October twentieth with a dessert. Mrs. M. J. Thornton, president, presided at the business session.

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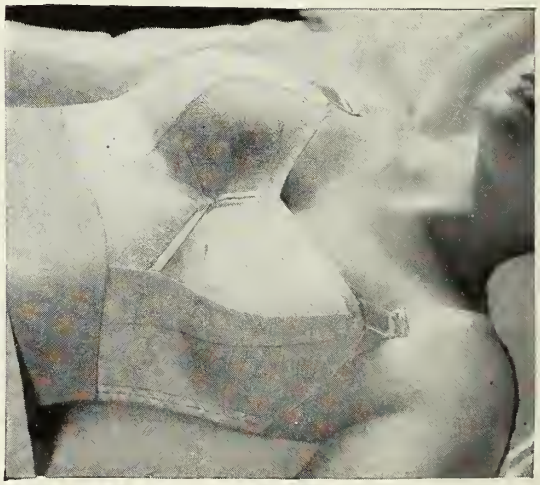

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# INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

*ISSUED MONTHLY under Direction of the Council*

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 38 FEBRUARY, 1945 Number 2


## FUNCTIONAL vs. ORGANIC HEART DISEASE*


NEWELL CLARK GILBERT, M.D.

CHICAGO, ILLINOIS


When the title of this paper was first suggested to me, I regarded it with some disfavor. It sounded just a little too legal for a medical paper. It savored, somehow, of divorce proceedings—but on second thought, the divorce proceedings were just what appealed to me. There are many conditions in which symptoms appear which are ascribed to the heart, the heart often being entirely innocent of any inherent fault of itself. These conditions should be divorced completely from any organic heart disease.

There are some conditions in which cardiac symptoms appear but in which these symptoms are precipitated or made worse by influences outside the heart itself. They are not due to anatomical changes in the heart. These influences may cause serious vasomotor changes in the coronary vessels or may influence the heart adversely in other ways, such as by change of rate or rhythm, and possibly tonus. This group of cases cannot be divorced from heart disease completely because they may be frequently associated with heart disease. In many cases there may be only such organic changes in the heart as are normal for the age. But even if there are no organic changes in the heart, cardiac symptoms occur, and even death itself may occur. Such cases should be given separate maintenance and should be considered as a group distinct from that in which organic changes are solely responsible for the symptoms. They are very important for two reasons: first, if they are of long duration they will eventually cause actual changes in the heart itself because of induced decreases in the coronary flow oft repeated over a long period of time; second, the condition is one which we may do a great deal to help. Often these reflex decreases in coronary flow or other reflex changes may be eliminated altogether. Usually they may be partially eliminated. They consist of reflexes arising from various sources, which play an important part in the causation of anginal attacks, or dypsnea, or edema of the lungs, by effecting a decrease in the coronary flow. They are usually vago-vagal reflexes. In coronary occlusion such a reflex greatly increases the mortality.

Many of these extracardiac influences are relatively simple affairs which are readily amenable to medication or management. Among such reflexes are the effects of meals, especially heavy or indigestible meals, which cause a reflex decrease in coronary flow in predisposed individuals. Similar reflexes may arise from a hiatus hernia, or a diverticulum of the esophagus or the duodenum, or from a peptic ulcer. The gall bladder is a frequent source of such reflexes. Facing a cold wind or breathing cold air through the nose may cause a vasoconstriction of the coronary arteries. Pulmonary emboli cause a reflex vasoconstriction of the coronaries, which is an important contributory cause of death in pulmonary infarction and calls for an immediate administration of atropine and papaverine, or aminophylline. Most of these reflexes can be inhibited entirely or in part by atropine, combined with a barbiturate. In some the cause can be removed. They are exceedingly important because of the damage they do, and because here at least is something which you can help. The history should be painstakingly scrutinized for any hint of such reflexes. It is advisable to make a roentgen examination even in the absence of such history. Prompt measures should be taken to abolish the reflexes. For instance, where the gall bladder is at fault, it can be removed.

One of the most important of such phenomena is the reflex vasoconstriction of the uninvolved coronary arteries in cases of coronary occlusion.

* Presented at the General Meeting of the Indiana State Medical Association, at Indianapolis, on October 4, 1944.

This reflex vasoconstriction of all of the arteries of the heart adds to the extent of the infarct, to the mortality, and affects the subsequent course of the cases who recover. This reflex can be obviated in whole or in part by the administration of atropine, subcutaneously.

There are many other extracardiac influences where heart symptoms are concerned, such as hypoglycemia, which is frequently overlooked, anemia, the use of tobacco, and many others which cannot be enumerated here. We should always be on guard for these extracardiac influences.

We will concern ourselves here with two functional cardiac conditions which must be entirely divorced from any organic heart disease. These two are the so-called "neurocirculatory asthenia" or effort syndrome, and the "functional heart murmurs." There are others, but we will confine ourselves to these two. These two conditions are of importance at all times. Both are frequently found in civilians, but they are of special importance at this time when so many young men are being released from the armed forces because of these conditions. Often we see these men returning with the idea that they have some serious and incurable malady and will be handicapped for the rest of their lives. This is most unfortunate because there is nothing to prevent them from leading happy and useful lives.

I regret that the term "neurocirculary asthenia" has so largely displaced the term "effort syndrome," which Sir Thomas Lewis originally applied to this group of symptoms. It is not an asthenia in the proper sense, and it is not entirely a circulatory phenomenon, for it involves, in varying degree, every function of the body which is under the control of the vegetative nervous system. And it is not an entity, but a very loose and variable collection of symptoms which are consequent upon effort. The patient's attention should not be drawn to his heart, or his nerves, or his general health by a name which seems to imply a real illness.

In spite of all that has been said and written concerning the subject, in this and the last war, nothing of basic significance has been added to Sir Thomas Lewis'[1] original description of the syndrome. Dr. MacFie Campbell's[2] article on the part played by instinct, emotion, and personality still very well covers the psychiatric side.

The symptoms of the effort syndrome are those which any of us might experience after exertion or after some emotional disturbance, such as fright. But here the patient breathes much more rapidly, and the pulse beats very much faster, and all this after only a very slight or minimal exertion.

When the patient with this effort syndrome is at rest, and not conscious of observation, the breathing is quiet and normal. But when he is up and about the respiratory rate increases, and on very moderate effort the breathlessness may be so marked as to be incapacitating and amount to a very real distress. The breathing is usually shallow, and the rate may increase to 50 or 60 per minute. In a few cases the respiration may be deep and rapid.

The pulse rate at rest is normal, or nearly so, and quite normal during sleep. But even on slight effort it increases to a much higher rate than is manifested in a normal individual even after extreme effort. In normal individuals the pulse rate returns to normal within two minutes or less after effort. In these patients the return to the previous level is much slower.

Often there is a subjective complaint of palpitation. This is usually nothing more than a consciousness of a heart beating rapidly and violently. In some cases there may be premature ventricular contractions after exertion. The blood pressure is usually normal while at rest, although occasionally it may be higher than normal. It may increase on exertion more than it would in normal people, largely because of the greatly increased heart rate.

Pain on exertion in the effort syndrome is very difficult to evaluate. Many of these patients are very prone to complain about any slight discomfort not always related to effort. But there are a great many who have very real discomfort or pain on exertion, directly referable to exertion. The pain may be substernal, but it is more frequently precordial. In some cases it may have the typical radiation of angina pectoris. Hyperalgesia to light touch over the precordial area may accompany the pain. It is probable that in many cases the complaint of pain or discomfort is exaggerated. It is also probable that in many of those who have definite pain there is a real basis for the pain. In a symptom complex characterized by a lowered threshold to autonomic stimuli, and to an overresponse to such stimuli, a vasomotor narrowing of the coronaries, or a failure to dilate in response to increased needs, might be expected.

Fainting is a symptom in a large proportion of the cases, usually as a response to some minor stimulus, such as having blood drawn, or receiving a hypodermic injection for immunization, or standing at attention too long. It may occur during examination. I have seen this happen on three occasions while I was examining a patient. In each case the heart rate slowed down to 50 or 60, and the pulse became almost imperceptible. The blood pressure fell until readings could not be obtained. Recovery was prompt. Such fainting attacks come on slowly, accompanied by profuse perspiration, pallor, giddiness, and a consciousness that the attack is impending. They cannot possibly be confused with epilepsy.

Perspiration is excessive. This may be true even at rest, but on exertion or during examination the entire body may become suffused with perspiration, and it fairly drips from the axilla. In the same

[1] Lewis, Sir Thomas: *The Soldier's Heart and the Effort Syndrome*, Second Edition, London, 1940.

[2] Campbell, MacFie: The Role of Instinct, Emotion, and Personality in Disorders of the Heart, *J.A.M.A.*, **71**:1621, 1918.

way, salivation may be increased, or the mouth may become dry on slight stimulus.

Giddiness is a frequent symptom. This is not a rapid rotation vertigo, but an unsteadiness with slow rotation, or a sense of rising and falling of the floor, as on a ship. It may follow exertion, or it may follow change of posture, or when standing or lying down. Fatigue appears readily on slight effort, and the patient may complain of exhaustion, or appear exhausted, without sufficient cause.

With all this there is a disinclination to effort, a lack of initiative, and a dread of undertaking any project. And here again are the same symptoms which occur in any of us with overfatigue, with the depression which follows a nervous strain, or with the weakness which follows a severe illness. The only difference is that with these people it takes less physical trauma to produce the symptoms of effort syndrome.

Objectively, these patients can frequently be diagnosed at a glance because of their dejected, defeated, stooped appearance, their rapid breathing, excessive perspiration, and cyanosed extremities. The cyanosis may be marked. It may be due to decreased ventilation because of the rapid respiratory rate, and it may be due to vasomotor changes. The hands are wet and cold, not wet and hot as in hyperthyroidism. There may be a coarse tremor. The corneal and pharyngeal reflexes are decreased in some. On the other hand, the general appearance may be quite normal and the objective findings absent while at rest.

Physical examination must reveal a heart normal in size and contour, with no more abnormalities of rhythm than an expiratory arrhythmia, or an occasional extra systole. Symptoms of the effort syndrome may occur in a damaged heart, but the diagnosis in such cases is the diagnosis of the cardiac abnormality present and not of the effort syndrome. A large proportion of these cases do have a systolic murmur at the apex or at the base. This may be present at one time and not at another, or may even appear during an examination, as in one of the cases already mentioned who fainted during an examination. If the heart is normal in size and contour, the murmur can be disregarded. If the heart is enlarged, or shows the contour of a heart with rheumatic heart disease, the case should not be considered as an effort syndrome.

In some cases there is what appears to be a loud mitral first sound which may be misleading and lead to the suspicion of a beginning mitral disease. It is due to a heart beating forcibly in the presence of a thin chest wall. But again, a normal-sized heart is demanded. Careful search must be made for the presence of any chronic infection which may be the causative factor, and a careful history must be elicited for any previous acute infection or any physical or psychical trauma.

Laboratory examinations, aside from any concurrent infections, are negative. In some cases there may be a hypoglycemia, or the chlorides may be low. There frequently is an overresponse of the leukocyte count to exertion.

It is evident from the summary of the symptoms that the entire syndrome consists of a very greatly exaggerated response to normal stimuli. What might happen to us on severe exertion or severe physical or psychical trauma happens here after very small stimulus, indeed. The same applies to the emotional responses, at least in part.

Now, just what is the etiology of the syndrome? It seems to me that it is all aptly summed up in the terse comment ascribed to Osler: "The fault lies in the germ plasm." They are born "constitutionally inferior," to use MacFie Campbell's term. As he states, "The term 'constitutional inferiority' is vague and without definite connotations. For that reason it may be used to note a very heterogenous group of persons who have, perhaps, only one factor in common, that biologically they do not have from the start the necessary stuff for a satisfactory response to their environment." That applies to these cases, but with some qualifications. Many would have been able to respond to a normal environment, but are not able to respond to a very abnormal environment. Many would have been able to go through life normally were it not for some physical or psychical trauma which a constitutionally normal person could meet satisfactorily.

I think we can divide those showing symptoms of the effort syndrome into five groups, very much as Lewis has done, although with slight and not very significant modications:

Group I—A large group who are so constitutionally inferior that they would be apt to show symptoms under any circumstances, and who are weak physically and nervously.

Group II—A group in whom the symptoms are a result of such trauma as chronic fatigue or overwork, because of insufficient rest and relaxation. Many of those in the Army may have had a too rapid transition from sedentary positions in civil life to the strenuous regimé of a training center. We see a similar train of symptoms in chronic fatigue anywhere, even in our own profession, with strain and overwork. What has been referred to as "staleness" is an example. In the first World War some aviators, after many hours in the air, would show signs of what was referred to as "staleness." The symptoms were identical with those of a mild effort syndrome. One man might show signs of staleness after only two hundred hours in the air. Another might stand hundreds more hours of flying, and another, after even a longer time, might never show any signs of such symptoms. The man who is constitutionally inferior might become stale sooner than the man who is less inferior, or who is constitutionally superior. Many of us, as we look back, can remember similar experiences in ourselves when, after long periods of fatigue, pulse and respiration have been more rapid, perspiration more profuse, and we have had the same loss of initiative and the same disinclination to go about our regular duties.

Group III—A group who were well until some slight infection, or an operation followed by an inadequate period of convalescence, offered sufficient physical trauma to bring on symptoms of effort syndrome in the predisposed. Such cases were frequent in the last World War, and are frequent in civil life.

Group IV—A group where the trauma is psychical, whose mothers had not raised their boys to be soldiers, or who in civil life have problems or doubts or fears which would be of small moment to those better endowed from the start.

Group V—A group who really have some mild, sub-clinical infection, such as an unrecognized tuberculosis, or an infection of the nasal sinuses, or some other mild, undiagnosed infection.

There is nothing here which many of us would not experience with overfatigue or with infection, or in the period following an infection. It is a question of the degree of constitutional inferiority and the amount of physical and psychical trauma. We should remember all this when these young men come to us and we are tempted to be impatient.

It might be appropriate to mention here that the reflexes which we spoke of earlier, which are carried through the vagus and which affect the heart and its vessels are much more prone to occur with chronic fatigue, overwork, and emotional disturbances. They are more frequent in what Huston refers to as the "spasmogenic aptitude"—not a very distant relative of the group which we have been discussing. In this same connection it is also interesting to bear in mind that the response of the carotid sinus to vagal stimulation increases gradually with age, beginning at about thirty. This may explain in part the increase with age in vasomotor changes in the coronary circulation in response to various reflexes.

Many of those with the effort syndrome have a systolic murmur. A great many cases of functional systolic murmurs occur in perfectly healthy people who do not have the remotest suspicion of any signs of the effort syndrome, and who do not have any possible heart disease. It takes much more than a systolic murmur for a diagnosis of "heart disease" to be made. Murmurs often receive too much attention anyway, attention which would be more productive if applied elsewhere.

In 1916, Sir James MacKenzie commented upon the fact that so many men were being rejected for military service because some physican had heard a very innocent systolic murmur. And many men were invalided out of the service, just as is happening now because of such a systolic murmur. In civil life such men are often subjected to medical treatment, or to strict supervision as to diet and exercise and what-not, who would be much better off physically and psychologically if left alone. They are lucky if they are not given digitalis. These men are frequently made to pay increased insurance premiums or are rejected for insurance. We are very safe in saying, as MacKenzie and Lewis have both said so long and so often, that a systolic murmur, no matter what its quality, is of itself of no significance in the presence of a normal-sized heart. The "of itself" must be emphasized. The "of itself" might refer to some other physical findings. "Of itself" must always exclude a history of rheumatic fever. Even with a history of rheumatic fever, a patient with a systolic murmur may die of old age. But we must always bear in mind the constant tendency of rheumatic fever to return.

We cannot go into an explanation of these murmurs. They occur at the base or at the apex. Probably the largest part are cardio-respiratory and are explained by Potain. They are extracardiac. When the heart contracts in systole it draws sharply away from the chest wall and from the adjacent lung, and under certain conditions the vacuum caused by the retraction is filled by a rush of air into the contiguous lung. Such murmurs occur during expiration and inspiration, drawing external air into the lung border on inspiration, and residual air on expiration. The murmur may or may not vary with inspiration and expiration. They are systolic because they are caused by cardiac systoles.

What appears to be a diastolic murmur at the apex may be caused by compression of the lingula of the left lung when the heart expands in diastole.

Another cause for murmurs may be changes in tonus or contraction or relaxation involving the valve rings. Weil reported that he could influence such murmurs by ocular compression. Hemic murmurs occur in anemia where there is loss of tonus due to the anemia. They are uncommon in these days of well-treated anemias, and were more common when chlorosis was common.

It is important that these so-called "functional" or "physiological murmurs" be kept in mind. We are constantly seeing young men who are being rejected by the armed forces, or who have been returned from duty to civil life because of them. They are worried and concerned about their condition, and have been sent well on the road to ill health and unhappiness. As Professor Link[3] says in his recent article in *American Mercury Magazine*, on the errors of psychiatry in the Army, in regard to suspected psychiatric cases, we must be very careful not to make mental and physical casualties out of the cases of functional murmurs and effort syndrome.

In the case of the functional murmur it is a question only of reassurance, but reassurance is not so easy after the patient has definitely been assured what a sick man he is. It will take patience and actual demonstration. A favorable response to an exercise tolerance test is often reassuring.

Treatment of the effort syndrome is difficult to formulate. You are not dealing with a definite disease, but with a symptom complex of varied background. What you do depends upon the patient, first of all. It depends upon which of the groups

[3] Link, Henry C.: The Errors of Psychiatry, *American Mercury Magazine*, July, 1944.

he belongs to. Remember that these groups have varying borders which may and often do overlap. Personality must be considered just as much as the history or the physical findings. It is just as much the part of a doctor's business to know and understand people as it is to know and understand medicine. He must be able to put himself into their skins and see and feel as they do.

The care of these patients is primarily the busi- of the family doctor, regardless of how much he may wish to push them off onto somebody else, especially to a psychiatrist.

In civil life the problem is much more simple than in the Army. The men are no longer in the environment which is responsible wholly or in part for their condition. If the case originated in civil life, it is more simple than that originating in the Army, because there is greater possibility of adjusting causative factors.

The presence of concealed infection must be carefully ruled out. The history must be scrutinized to determine just what physical or psychical trauma precipitated the condition. Where chronic fatigue is a factor, a great deal can be done by rest and change and recreation. A few weeks in a rest camp completely restored the cases of staleness in the air service during the last war.

The use of graduated exercise, starting with a very few minutes of the simplest kind of exercise, and increasing by small increments only after the patient is symptom-free during or after the first group of exercises, will help a large proportion. I cannot go into the details here, but will refer you to Sir Thomas Lewis,[1] Bertrand Smith,[4] and others. Good results are obtained in about half the cases, and some kind of results are obtained in a part of the other half, with regular out-of-door life and carefully-graduated and carefully-supervised exercise.

They should not be allowed to consider themselves ill or the subject of heart disease or of nervous disease. A few may need help from a psychiatrist, but most of them can be managed and restored to health by the family physician without drugs, particularly without the help of sedatives, but always with understanding, and with good, solid, old-fashioned Indiana common sense.

[4] Smith, Bertrand:
(a) The Possibilities of Physical Development in Cases of Effort Syndrome by Means of Graduated Exercises, *Archives of Internal Medicine*, **24**:321-331, 1919.
(b) Physical Exercises in Those in the Cardiovascular Service, *J.A.M.A.*, **72**:103-107, 1919.

# THE MANAGEMENT OF THE "FIRST PRIORITY" SURGICAL CASUALTY FROM THE ANESTHETIC VIEWPOINT

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The management of the "first priority" surgical casualty from the anesthetist's viewpoint presents one of the most difficult problems in war medicine. This type of casualty is defined as a seriously wounded individual who cannot be safely evacuated further to the rear than the "first priority" hospital without surgery (platoons of field hospitals are employed for this purpose). Such a casualty is considered non-transportable and is sent directly by hand-litter carry from the divisional clearing station to this small forward surgical hospital, which is placed in physical conjunction with the clearing station. There is so little recorded information on the management of these casualties by anesthesiologists who have cared for them that it appears worth while to record some of our experiences which have been gained as anesthetist on a general surgical team of an auxiliary surgical group functioning in medical installations of the Fifth Army.

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The great majority of patients accepted for "first priority" surgery in the most forward installations are in the state of severe shock. Obviously, it is necessary to direct primary attention toward correction of the shocked state. It is well to remember that in patients in which shock is not demonstrable, the factors which provoke this phenomenon may be present and become manifest or precipitated by the administration of an anesthetic agent. The largest percentage of these cases are thoracic, abdominal, and thoraco-abdominal injuries. A large number of these also have extensive wounds of the soft tissue or bony structure of the extremities and traumatic amputations. A small percentage of cases treated have maxillofacial and cranial injuries.

The problem of replacement therapy has been a much-discussed subject in this theater. In the past few months we have been fortunate in having the opportunity to work with a mobile laboratory engaged in clinical investigation of these problems and equipped to give accurate and valuable information concerning the status of the elements of

the circulatory system, both preoperatively and postoperatively. With few exceptions the severely-shocked patient, in which hemorrhage has been the predominant agent in production of shock, has had a decreased plasma volume, hematocrit, hemoglobin, and total blood volume. Prior to this information we were working on a basis of one unit of plasma to 500 cc. of citrated whole blood. During the last series of 200 cases we have been using whole blood liberally, averaging between 1,500 to 2,000 cc., and three units of dried plasma per patient. However, the amount of whole blood given to each patient is variable. While it is not common to give a total of 3,000 cc. of whole blood to a patient preoperatively, this amount may be required. If evidence of dehydration was present, 5 per cent glucose in physiological saline solution was administered after the blood pressure was stabilized within approximately normal limits. The conventional practice of hemorrhage control, splinting, heat, minimal handling of the patient, and placing the patient in the shock position (providing the injury permitted) was carried out. In addition to preoperative shock therapy, we routinely evacuate the gastric contents of all abdominal patients by means of either a large or small gastric tube. The size of the gastric tube used is dependent upon the demands of the case.

We were clinically unable to establish a precise criterion for operability of any patient who was or had been in profound shock. However, we were inclined to believe that a patient with a sustained systolic blood pressure of 100 mm. of Hg., and a pulse rate of 120 per minute or less was a fairly good operative risk. If surgery is delayed awaiting more improvement in these cases, they fail and go into a state of irreversible shock. The time required to reach the optimal goal through resuscitation measures was variable, but two and one-half to three hours was the average time per patient. For those who failed to make a satisfactory response during the above regime, it was often deemed necessary to operate despite the great risk, realizing the possible presence in the peritoneal and sometimes the pleural cavity of gastric and/or fecal contents and hidden, uncontrolled hemorrhage. These complications often contribute to the state of severe shock which will be relieved only by evacuation of these contents, as well as control of the hemorrhage. During the course of the operation, replacement therapy was continued and an adequate flow was assured, should the need arise, by cannulating at least two large veins. On several occasions we have used the sternal route for the administration of whole blood with satisfactory results.

The problem of premedication remains one of individualization as to the needs of the patient. It seldom has been necessary in the most forward hospital unit to give additional morphine as these patients usually have received an adequate dosage of the drug before admission. The shocked patient absorbs the drug slowly until the circulation begins to approach normal, at which time the cumulative effect of repeated doses is often rapidly attained with the resultant marked depression of respiration. This undesirable action obviously complicates the problems associated with the anesthetic procedure. For patients requiring additional sedation, morphine dosages of one-sixth grain is maximal but seldom required preoperatively in "first priority" surgical cases. The desired balance between morphine and scopolamine or atropine could seldom be secured in the non-transportable casualties. By the very nature of the injuries and presence of respiratory depression due to morphine, additional sedation with barbiturates and avertin is eliminated from use as pre-anesthetic drugs.

Due to the serious nature of these cases, it is most important that a rapid and tranquil induction to anesthesia is obtained. It is essential, especially in traumatic injuries of this severity, to eliminate as much as possible the period and degree of excitement. It has been our experience that excitement of any degree causes difficulty in maintaining a level surgical plane, definitely contributes to deterioration of the patient's condition during surgery, and to postoperative shock.

In all of these patients the intratracheal administration of ether with a high oxygen concentration and soda-lime cannister is used. Induction of anesthesia is accomplished with a mixture of 80 per cent nitrous oxide and 20 per cent oxygen, which is satisfactory in our hands. The oral route for intubation is preferred because of the ease of insertion, frequent necessity of the use of the intratracheal catheter with a "cuff," and the high incidence of low-grade nasopharyngeal infection.

The surgical plane of anesthesia these patients are carried in is variable and depends largely upon the physical condition of the patient. In our experience, on the average, these patients best withstood anesthesia if maintained in the lower first plane or upper second plane of surgical anesthesia. However, most patients were able to withstand deeper anesthesia for short periods of time if the surgical procedure demanded. Beyond this period of time and depth the patients condition deteriorated rapidly.

In dealing with wounds involving the thorax, positive pressure and controlled respirations, although not always necessary, are of great aid in facilitating the operative procedure. It has been our practice to frequently re-expand and not to permit complete collapse of the lung during surgery, and to expand the lung upon completion of surgery by permitting air in the pleural cavity to escape through a catheter. The catheter is removed when the maximum amount of air is expelled by the advancing lung obliterating the pleural cavity. In those cases where drainage of the pleural cavity is desirable, the catheter is anchored in situ, and expansion of the lung completed by allowing the air to escape through a water trap.

In the surgical care of intra-abdominal injuries, liberal incisions are used more or less routinely to

facilitate the speed of repair of these injuries. Therefore, in using such incisions it becomes necessary to have very good relaxation to prevent evulsion of intestinal contents out on the abdominal wall and to permit easy closure of such incisions. In some patients whose conditions would not permit deeper anesthesia, supplementary anesthesia, by means of bilateral intercostal nerve block, was done with satisfactory results.

At the completion of the surgical procedure attention is given immediately to the respiratory tree, which includes cleansing of the nasopharynx, trachea, and bronchi. This is done by either the use of a small urinary catheter with an adequate number of apertures, or the bronchoscope. It has been our experience under average circumstances that the cleansing of the tracheobronchial tree with a catheter is adequate if done properly, the use of the bronchoscope being reserved for removal of gross blood or other foreign bodies lodged in the respiratory tree.

In the postoperative care of these patients it is often necessary to do repeated tracheobronchial aspirations, and, upon occasions, bronchoscopy. Either procedure is done routinely until the respiratory tree is comparatively free of accumulated secretions. To avoid incisional pain and thereby assist the patient to cough, bilateral intercostal nerve block has been done upon many of our patients with satisfactory results. This procedure also has the advantage of making the patient more comfortable, which possibly aids in the smoothness of the postoperative course.

In a few cases which had injury to the arterial supply of the extremities, complicating abdominal and thoracic wounds, stellate or lumbar sympathetic ganglia block was done. These procedures were done with the hope of increasing the circulation, or at least lowering the line of demarcation of the injured extremity. The results in all these cases were variable.

## SUMMARY

The management of the non-transportable casualty from the anesthetist's viewpoint presents a difficult problem. The anesthetist is dealing with patients who have been in a severe state of shock. Vigilance must be maintained for the reappearance of shock during surgery, and proper replacement therapy begun. This should be anticipated preoperatively and vigorous therapy be assured by cannulating at least two large veins, and, if necessary, use of the sternal route. There is no good substitute for whole blood, and it should be given liberally in accordance with the severity of shock. Induction of anesthesia should be rapid, tranquil, and maintained under intratracheal ether-oxygen. The depth of anesthesia should be compatible with the needs of the surgeon. In thoracotomies, the lung should be frequently re-expanded during the procedure, and completely at the termination of the surgical procedure. In the postoperative care of these patients it is often necessary to do repeated tracheobronchial aspirations or bronchoscopy until the respiratory tree is free from accumulated secretions. Regional and sympathetic ganglia block is a valuable aid in the convalescence of the patient, if used when indicated.

## ILLUSTRATIVE CASE REPORTS*

*Case 1*—This case was admitted to the hospital five hours after injury, in severe shock. The physical examination revealed a perforating wound of the right upper quadrant with protrusion of some fatty tissue. The abdomen was tender and rigid. X-ray findings showed a foreign body lying to the left of the midline, between D-12 and L-1. Blood pressure 50/0, pulse 148, and respirations 26. The patient was given the conventional shock therapy of heat, shock position, oxygen, whole blood, and plasma. The amount of 2,000 cc. of whole blood and two units of dried plasma was given in a period of two and one-half hours. Upon arrival in surgery, the blood pressure was 110/58, pulse 124, respirations 18; gastric drainage was established before induction of anesthesia. Anesthesia was nitrous oxide-oxygen induction and maintained on ether-high tension oxygen intratracheal technic. Replacement therapy continued throughout anesthesia. Blood pressure remained at pre-anesthetic level during anesthesia.

Surgical findings were: two perforations of the jejunum, one perforation of the stomach, and a gutter wound of the liver. Immediately following completion of the surgical procedure tracheobronchial aspiration and bilateral intercostal block was done. Upon recovery from the effects of the anesthetic, the patient was able to cough and breathe deeply during the first twenty-four hours without incision pain. The postoperative course was uneventful, and the patient was evacuated upon the fourteenth postoperative day. This case illustrates the value of intercostal nerve block.

*Case 2*—This patient was injured December 20, 1943, at 1300 by a shell fragment. He was received in the hospital about fifteen hours after being wounded, and was in severe shock on arrival with a blood pressure of 70/10, and a pulse that was too rapid to count. This patient was then given two units of plasma and 1,000 cc. of blood, and brought into the operating room. Physical examination showed a perforating wound of the left chest entering at about the sixth rib, anteriorly, and showing a point of exit at the ninth rib, posteriorly. There was also a penetrating wound in the left lumbar area. The abdomen was rigid and tender, and the x-ray showed a clouding of the left chest. The patient was induced with nitrous oxide-oxygen, and then carried on endotracheal ether oxygen. The wounds of the chest were debrided and a thoracotomy then performed by resecting the sixth rib. A through-and-through hole in the lower lobe of the lung was sutured and the chest closed, bringing a catheter

* All illustrative cases were operated by Major James M. Sullivan.

out to a water seal. A laparotomy was then done, two holes in the jejunum were sutured, and a hole in the sigmoid was exteriorized through a stab wound. Peritoneal closure was then started, and it was necessary to carry the patient into the third plane to permit the surgery to be accomplished even though the patient was in a very precarious position at this time. Thereafter the anesthesia was discontinued and pure oxygen was given. The patient received two blood transfusions during the operation, which lasted three hours. Death occurred within the next hour in spite of all our efforts to control the deepening shock. This case illustrates the effect of long and tedious procedures on a profoundly shocked case under deep anesthesia. We might have been able to salvage this case by conservative treatment of the chest pathology and augmenting the inhalation anesthesia with bilateral intercostal nerve block. The latter procedure would make it unnecessary to carry the patient so deeply. Our present custom is along these lines.

*Case 3*—This soldier was injured by a shell fragment on May 24, 1944, and after a time lag of seventeen and one-half hours was brought into the hospital. He was found to be in only mild shock and presented a penetrating wound of the right lower chest and the right foot. Two blood transfusions were given preoperatively, and two units of plasma. Under endotracheal ether oxygen anesthesia the wound in the chest was debrided and enlarged. A hole was found in the diaphragm in the costophrenic angle, which communicated with the right kidney area. The kidney was drained subcostally, and the holes in the diaphragm and the pleura were sutured. A tight closure was also performed on the chest wall. There was very little blood lost at the operation, and he also received two blood transfusions during its performance. At the end of the operation the patient went into an acute pulmonary edema which finally responded to bronchoscopic drainage, venesection, and atropine intravenously. From information obtained later, we found that he had received at least four units of plasma before he entered the hospital, and this is believed to have had a definite influence in the development of the severe pulmonary edema.

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# DIAGNOSIS AND PROGNOSIS OF BUNDLE-BRANCH BLOCK

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The diagnosis and the prognosis of intraventricular conduction defect have become of increasing importance during the last sixteen years. The finding of intraventricular conduction defect was some years ago considered a very serious omen. Now, however, through the increasing use of the electrocardiograph as a clinical aid, it is coming to be recognized that the lesion itself is not necessarily of grave importance.

The pathogenesis of intraventricular block has been summarized by Yater.[1] Graybiel and Sprague,[2] and King,[3] among others, state that most of the patients died within fourteen months after the cardiac lesion was first recognized. However, Wood, Jeffers, and Wolferth[4] conclude that in the absence of other heart disease bundle-branch block is not necessarily an ominous sign. Sampson and Nagle[5] then pointed out in their follow-up series that, although there is a high mortality rate in the first year after discovery of the lesion, a remarkable diminution in the mortality rate occurs in those patients who survive this period. Bishop,[6] in the most recent survey, is in accord with this conclusion.

Katz and Kaplan[7] report a series of 126 patients. Their brief summary is as follows:

"(1) The character of the underlying disease rather than the presence or absence of intraventricular block determines the prognosis, although intraventricular block carries with it a high mortality rate in the first year, particularly in the first three months.

"(2) We found a high mortality rate within a year of the discovery of the conduction lesion. Patients surviving this period have a materially

[1] Yater, Wallace M.: Pathogenesis of Bundle-Branch Block, *Arch. Int. Med.*, **62**:1, 1938.

[2] Graybiel, Ashton, and Sprague, H. B.: Bundle-Branch Block an Analysis of Three Hundred Ninety-five Cases, *Am. J. Sc.*, 185-195, 1933.

[3] King, J. T.: Bundle-Branch Block—A Case with Special Reference to Incidence and Prognosis, *Am. Journal Sc.*, 187-189, 1934.

[4] Wood, F. C.; Jeffers, W. A., and Wolferth, C. C.: Follow-up Study of Sixty-four Patients with Right Bundle-Branch Block Conduction Defect, *A. Heart Journal*, **10**:1056, 1935.

[5] Sampson, J. J., and Nagle, O. E.: The Prognosis of Bundle-Branch Block and Other Intraventricular Conduction System Lesions, *Am. J. M. Sc.*, **191**:88, 1936.

[6] Bishop, L. F., Jr., and Carden, G. A., Jr.: The Prognosis of Bundle-Branch Block, *Am. Heart Journal*, **17**:275, 1939.

[7] Katz, L. N., and Kaplan, L. G.: The Prognosis of Intraventricular Block, *Am. Heart Journal*, **18**:145, 1939.

better life expectancy. Apparently a relatively benign type of heart block occurs.

"(3) Neither the configuration of the electrocardiogram nor the duration of the QRS deflection is of prognostic significance."

The usual method of making a diagnosis is dependent upon the symptoms and signs of the disease. The symptoms and signs in bundle-branch block are nil, except that the sign may be a re-duplication of one or both heart sounds due to somewhat asynchronous contraction of the ventricles resulting from bundle-branch block, but this is not a constant sign. However, if there is a re-duplication of both heart sounds intraventricular block should be looked for.

The diagnosis of bundle-branch block is made only by the characteristic electrocardiogram. The QRS is broadened, coarsely notched, and frequently of considerable amplitude; the T wave is apt to continue quickly in the opposite direction to the main initial deflection. When the initial deflection is upward in Lead I and downward in Lead III, the curves represent left bundle-branch block. When the deflection is down in Lead I and upward in Lead III, it is right bundle-branch block. Lead I is more important than the other two leads in determining whether the block is in the right or left branch.

If there is a prominent S wave in Lead I, the block is on the right side. If there is a prominent R wave and no S wave, it is on the left. This is a new terminology. There is also a third type of block which is called "indeterminate." The characteristic electrocardiogram of intraventricular block will show a QRS interval longer than .11 of a second in duration.

I am reporting eleven cases of bundle-branch block, not with the idea that this is a sufficient number to prove the subject of my paper but to serve as a stimulus to other members of our profession to suspect this disease or condition when a gallop rhythm is heard, and then have an electrocardiogram made to confirm the diagnosis, and remain in contact with the case. In this way a large number of cases will be on record to indicate whether we are going in the right direction.

*Case I*—Mr. W. W., aged sixty-seven. His chief complaints were shortness of breath, edema of the legs, and anasarca. This condition began in May, 1938. On August 16, 1938, the heart revealed a systolic and a diastolic murmur at the base, and a systolic murmur at the apex. The blood pressure was 120/80 millimeters of mercury. The chest revealed rales and flatness at the base of each lung. There was a pitting edema of the sacrum and the lower extremities, and a distended abdomen. There was a fistula of the scrotum and the rectum. There was a bilateral inguinal hernia. The Wassermann was four plus; urine yellow, with 1012 specific gravity; and the albumin and sugar were negative.

The electrocardiogram was made October 8, 1938. The QRS interval was .12 of a second. In Lead I the R wave was up with an inverted T wave. In Lead II there was an R wave, an S wave, and an inverted T wave. In Lead III there was a small R wave with a deep S wave, and an upright T wave. The patient died July 4, 1939. Duration of life from the time the electrocardiogram was made was eight months and twenty-six days.

*Case II*—Mr. J. T., aged fifty-three. His chief complaints were dyspnea and pain over the region of his heart, which began a year prior to the examination. There was a see-saw murmur at the base of the heart, and a systolic murmur at the apex. The arterial blood pressure was 110/70 millimeters of mercury. Hernias were found in the navel and right inguinal areas. The urine was negative and the Wassermann four plus. The electrocardiogram was made March 4, 1938. The QRS interval was .12 of a second. In Lead I the R wave was up and the T wave was inverted. In Lead II were found an R wave and an S wave, with a diphasic T wave. In Lead III there was a small R wave with a deep S wave and an upright T wave. The duration of life to date was six years, five months and ten days.

*Case III*—Mrs. L. L., aged sixty-eight. Her chief complaints were dyspnea, dizziness, and painful and swollen ankles. There was a systolic murmur at the base of the heart with $A^2$ accentuated. The arterial blood pressure was 170/90 millimeters of mercury. The urine and Wassermann were negative. The electrocardiogram was made September 9, 1939. The QRS interval is .12 of a second. The separate waves are notched and slurred. The R wave is up in Leads I and II with the T wave inverted. In Lead III there is an S wave with an upright T wave. She died May 24, 1943. Duration of life was three years, eight months, and fifteen days.

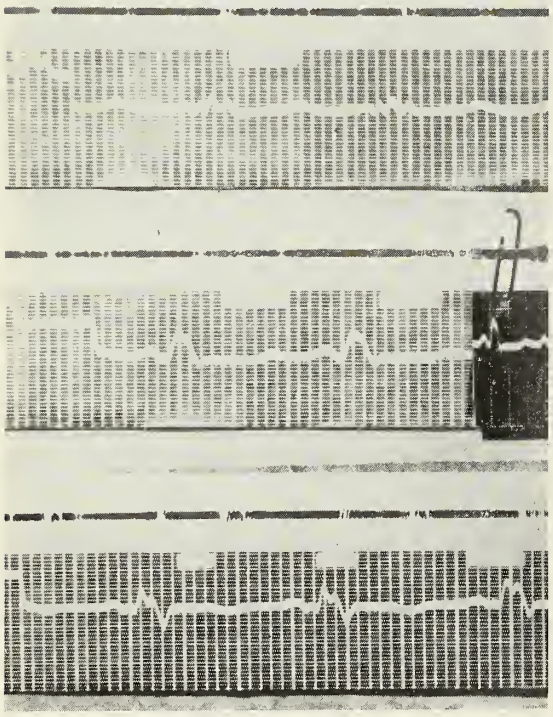
*Case IV*—Mr. G. W., aged fifty-four. His chief complaints were dyspnea and swelling of the abdomen and lower limbs, which began three months before the examination. There was a systolic murmur at the apex of the heart. The abdomen was distended and the lower extremities showed marked pitting edema. The arterial blood pressure was 150/90 millimeters of mercury. There was a four plus albumin and a negative Wassermann. The electrocardiogram was made August 29, 1938. The QRS interval was .12 of a second wide, less than five millimeters high, and slurred and notched in all three leads. The R wave was up in all three leads with a diphasic T wave. He died July 27, 1943. Duration of life was four years, ten months, and twenty-eight days.

*Case V*—Mr. C. C., aged twenty-four. His chief complaints were pain around his heart, and dizziness with sudden onset of weakness in all joints. He had had painful joints since childhood. Pain over his heart had a duration of three to ten minutes and was relieved by his remaining quiet, belching or vomiting. The urine and Wassermann were negative. There was a systolic murmur at the apex of the heart. The arterial blood pressure was 110/60 millimeters of mercury. The electrocardiogram was made December 17, 1938. The QRS interval was more than .12 of a second, upright in all three leads, and the separate waves were slurred and notched. The T wave was diphasic in Lead I and was inverted in Leads II and III. He is alive to date, five years, seven months, and twenty-nine days since the electrocardiogram was made.

*Case VI*—Mrs. L. T., aged seventy-eight. Her chief complaints were dyspnea, frequency of urination, and painful and swollen lower extremities. Her right knee was injured in 1938, after which she was not able to walk well. She had an ulcer on her left breast for more than six years. There was a systolic murmur with a diastolic gallop rhythm at the apex of the heart; at the base of the heart were a systolic and a diastolic murmur. The arterial blood pressure was 170/80 millimeters of mercury. The urine and Wassermann were negative. The electrocardiogram was made February 5, 1940. The QRS interval was .12 of a second. In Lead I there was an R wave with a deep S wave followed by a diphasic T wave. In Lead II the R wave and S wave were followed by a diphasic T wave. In Lead III a Q wave and an R wave were followed by a disphasic T wave. The patient died July 15, 1940, the duration of life being five months and ten days.

*Case VII*—Mrs. E. A., aged sixty-nine. When examined January 6, 1943, her chief complaints were dyspnea, cough, and soreness of the chest for three days. She had had dyspnea, orthopnea, and dizziness, and also pain in her joints for more than ten years. There was a large nodular mass in her neck. Chest rales were heard at the base of the lungs, with dulness over the right base. The heart rate at the apex was 110 per minute. Also at the apex were a systolic murmur and a gallop rhythm. Along the left sternal border was a systolic murmur and a diastolic gallop rhythm. The arterial blood pressure was 210/100 millimeters of mercury. The temperature was 101 degrees Fahrenheit, the pulse rate 110, and the respiration 30. On January 7, 1944, at 5:00 p.m., she became extremely ill. Attempting to get out of bed, she became helpless, with difficult breathing and bluish lips. A physician saw her and gave some relief. The stethocardiogram was made January 9, 1943. The QRS interval was .12 of a second, five millimeters high, and slurred and notched in the three leads. The T wave was up in Leads I and II. In Lead III there was an S wave with an inverted T wave. She is alive to date. Duration of life up to the present time is one year, seven months, and seven days.

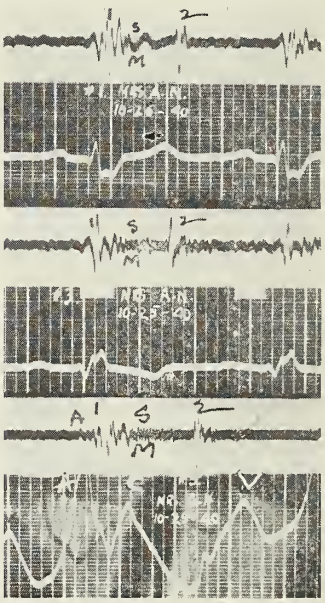
**CASE VII**



*Mrs. E. H.—Indeterminate*

*Case VIII*—Mrs. F. N., aged seventy-five. Her chief complaints were dyspnea and dizziness for more than seven years. In the mitral area were a presystolic murmur, a loud first sound, and a harsh systolic murmur. In the aortic area were a loud systolic and a soft diastolic murmur, and an accentuated second sound. The arterial blood pressure was 150/90 millimeters of mercury. There was a four plus albumin with a hyaline cast, and a negative Wassermann. There was present in the stethogram an audible auricular sound, recordable but seldom heard because its pitch was below the level of human audibility. The venous pulse tracing was taken over the right jugular vein. The auricular sound was less obvious, but its slight deflection occurred simultaneously with the peak of the A wave. The first heart sound occurred during the down slope of the A wave and terminated with the peak of the C wave. The second heart sound occurred during the up slope of the V wave. A systolic murmur trailed off the first heart sound and had a duration of about two-thirds of a systole. The higher pitched systolic murmur commenced with the peak of the C wave of the venous tracing. There was a ripple marked X on the venous tracing, which occurred between the A and C waves. This sort of ripple is a common occurrence in the venous pulse tracings and corresponds to the first heart sound. The stethocardiogram was made October 19, 1940. The QRS interval was more than .12 of a second. In Lead I were a small R wave, a broad S wave, and an upright T wave. In Lead III were a Q wave and a notched and slurred R wave with the T wave upright. The R wave was less than five millimeters high. She died March 10, 1941, four months and fifteen days after the stethocardiogram was made.

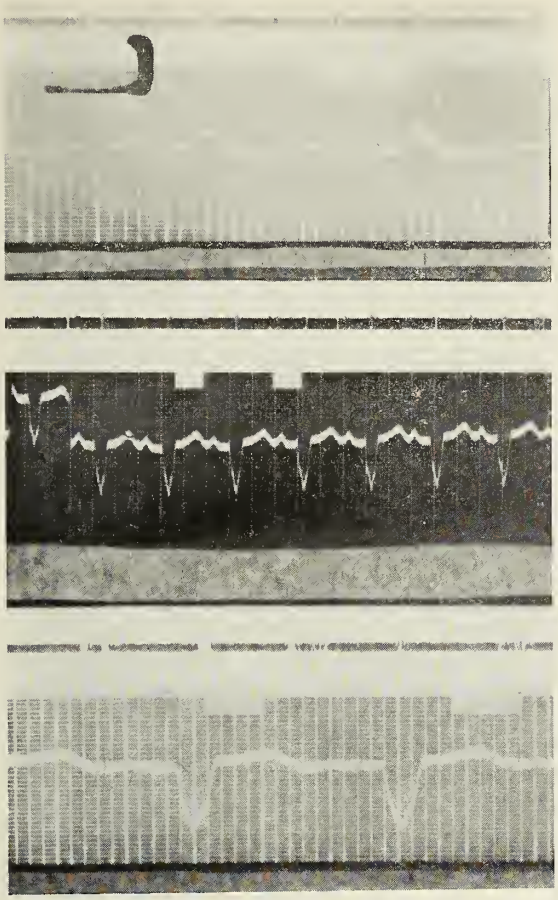
**CASE VIII**



*Mrs. F. N.—Right Bundle-Branch Block*

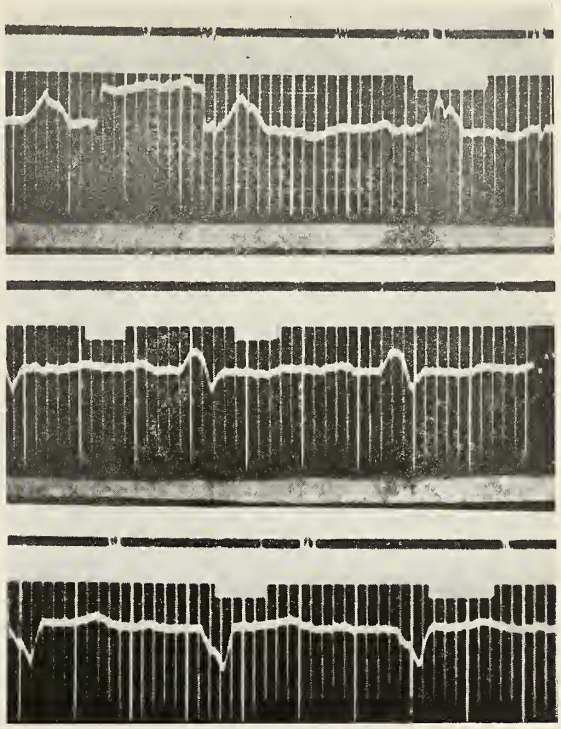
*Case IX*—Miss M. H., aged fifty. She complained of pain in her left chest, radiating down the left shoulder to the elbow, beginning in February, 1943, while she was on her way to the grocery store. The pain was brought on by slight exertion, talking, or laughing, and at times it seemed to cut off her breath. The duration of pain was ten to thirty minutes, occurring two or three times a day. The size of the heart was found to be increased in the sixth intercostal space on the left. There was a systolic and a diastolic murmur in the mitral area. In the aortic area could be heard a loud first sound and a diastolic gallop rhythm. Arterial blood pressure was 190/120 millimeters of mercury. The serology and urine were negative. The stethocardiogram was made on October 21, 1943, which revealed in the mitral area a first sound with a short systolic murmur, and a second sound followed by a diastolic gallop rhythm. In the aortic area the stethogram revealed a second sound followed by a diastolic gallop rhythm and a diastolic murmur. The QRS interval was more than .12 of a second, and was slurred and notched in all three leads. The R wave was up in Lead I with the T wave in the opposite direction. In Leads II and III there was an S wave with an upright T wave. The patient is alive to date, nine months and twenty-five days having elapsed since the stethocardiogram was made.

CASE IX



*Mrs. M. H.—Left Bundle-Branch Block*

CASE X

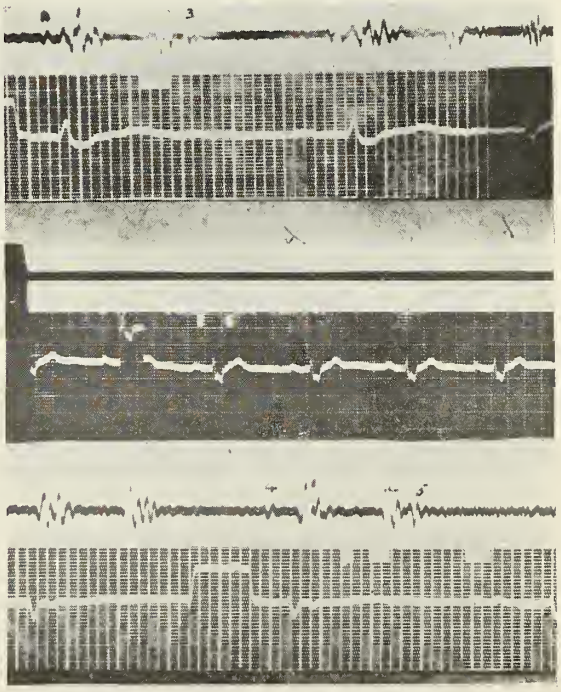


*Mr. A. R.—Left Bundle-Branch*

*Case X*—Mr. A. R. He complained of dyspnea, orthopnea, and edema of the ankles. This had begun March 1, 1944. The heart was increased in size in the left side at the sixth intercostal space. The first sound was of moderate intensity with a short systolic murmur followed by a split-second sound. Along the left sternal border the first sound of moderate intensity was followed by a systolic murmur with a re-duplicated second sound and a short diastolic murmur. The arterial blood pressure was 230/150 millimeters of mercury. The urine was four plus albumin and 1015 specific gravity. The serology was negative. The stethogram was made March 15, 1944, and revealed in the mitral area a presystolic gallop rhythm between the P and R waves of the electrocardiogram with a split second sound. In the aortic area it revealed a systolic murmur followed by a second sound with a diastolic gallop rhythm and a short diastolic murmur. The QRS interval was more than .12 of a second and was notched and slurred in the three standard leads. The R wave was up in Lead I and the T wave was inverted. There was an S wave in Leads II and III with upright T waves. The patient is alive to date, five months and three days later.

*Case XI*—Mr. S. G., aged seventy-two. He was admitted to the City Hospital on November 18, 1937. His chief complaints were dyspnea, orthopnea, and edema of the ankles for more than two and one-half years. The urine and serology were negative; his arterial blood pressure was 170/80 millimeters of mercury. The stethocardiogram was made September 14, 1940. It revealed a presystolic gallop rhythm between the P and R waves of the electrocardiogram. Coming shortly after the R wave was a loud first sound, and .40 of a second later, or at the end of the T wave, the second heart sound was followed in .10 of a second by a diastolic gallop rhythm in the mitral area. These same sounds were heard in the aortic area. The QRS interval was more than .12 of a second. The R wave was greater than the S wave in

CASE XI



*Mr. S. G.—Left Bundle-Branch Block*

Lead I, with an upright T wave. In Leads II and III the S waves were greater than the R waves, with the T wave in the opposite direction. The patient is living, and the duration of life since the beginning of the hospital record is six years, six months, and five days; the duration since the stethogram was made is three years and eleven months.

Summary and conclusion: Presystolic gallop rhythm was found in one case, diastolic gallop rhythm in one, and in three cases both presystolic and diastolic gallop rhythm were found. The diagnosis of bundle-branch block can be made only by the electrocardiogram. Left bundle-branch block is more common but less fatal than right branch block. Bundle-branch block is more frequent in men than in women, and is more frequent in old age.

SYNOPSIS

| Type of Block | Number of Cases | Living or Dead | Per cent of Deaths | Etiology | Duration of Life After EKG | | | Age | Sex |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Yrs. | Mo. | Days | | |
| Left bundle branch | 6 | | 33 1/3 | Syphilis | | 8 | 26 | 67 | M |
| | | D | | Syphilis | 6 | 5 | 10 | 53 | M |
| | | L | | Rheumatic Fever | | 5 | 3 | 52 | M |
| | | L | | Hypertension | 3 | 11 | | 72 | M |
| | | L | | Hypertension | | 9 | 25 | 50 | F |
| | | L | | Hypertension | 3 | 8 | 15 | 68 | F |
| | | D | | | — | — | — | — | |
| | | | | | 16 | 1 | 16 | 362 | |
| Right bundle branch | 2 | | 100 | | | | | | |
| | | | | Hypertension | | 5 | 10 | 78 | F |
| | | D | | Hypertension | | 4 | 15 | 75 | F |
| | | D | | | — | — | — | — | |
| | | | | | | 9 | 25 | 153 | |
| Indeterminate | 3 | | 33 1/3 | Hypertension | | | | | |
| | | | | Rheumatic Fever | 1 | 7 | 7 | 69 | F |
| | | L | | Rheumatic Fever | 5 | 7 | 29 | 24 | M |
| | | L | | Hypertension | 4 | 10 | 28 | 54 | M |
| | | D | | | — | — | — | — | |
| | | | | | 12 | 2 | 4 | 147 | |

## ABSTRACT

### A NEW TYPE OF MAGNET REMOVES FOREIGN BODIES FROM STOMACH

A new type of magnet, by which magnetizable foreign bodies in the stomach and windpipe can be removed, thus eliminating operations which often are necessary to remove such objects, is described in *The Journal of the American Medical Association* for January 13, by Murdock Equen, M.D., of the Ponce de Leon Eye and Ear Infirmary, Atlanta, Georgia.

The magnet is composed of alnico, an alloy of aluminum, nickel, cobalt, and iron. For the past two years, Dr. Equen says, the new alloy magnet has been available as a small permanent type for use in removing foreign objects from the eye.

The instrument reported for use of the magnet is composed of a tube to which the magnet is attached and which is introduced into the stomach through the mouth and esophagus. At the other end of the tube is a rubber bulb which is used for inflating the stomach. This inflation lifts any collapsed portion of the stomach from the foreign object, such as a pin, allowing the magnet to be passed about freely, and the foreign body is thus unimpeded in being attracted by the magnet.

As Dr. Equen explains, the removal of foreign bodies from the stomach and windpipe by means of the gastroscope and flexible forceps is a very difficult procedure. The constant shifting of the position of the foreign body, in a space as large as a stomach, makes it very difficult to establish contact between the forceps and the object.

Alnico magnets require a considerably stronger magnetizing force to magnetize them completely than do other types of permanent magnet alloys, the author says. At the same time, alnico has more available external energy or attracting-power for a given volume or size than has any other permanent magnet material known at the present time.

Dr. Equen presents in his paper a case report that he says is typical of the entire series of cases of foreign bodies removed by the new magnet. He tells of a girl, aged nineteen months, who had swallowed her mother's hairpin twelve hours previous to the time the baby was brought to him. The new instrument was passed down the esophagus and introduced into the stomach of the child. This was done against a background of a fluoroscopic screen which revealed, by means of x-ray, the position of the hairpin and also of the magnet. The stomach was then inflated, the pin quickly coming into the range of the magnet to which it was attracted and then withdrawn from the stomach. The entire procedure lasted only eight minutes, he said.

"The new alloy magnet, alnico," Dr. Equen concludes, "is being proved of great value to medicine. For the past two years it has been available as a small permanent type eye magnet. Only a minority of foreign bodies of the food and air passages are magnetizable, but among those which are, the use of this instrument will render unnecessary many abdominal operations and decrease bronchial instrumentation."

# THE RESPONSIBILITIES OF THE LOCAL HEALTH OFFICER*

F. R. NICHOLAS CARTER, M.D.

SOUTH BEND

It is an honor and a pleasure for me to say that I am one of Indiana's health officers. I have served my community as health officer for the past nine years. Following are some of the facts and observations that I have made during this period of service.

### What Are the Requirements of a Health Officer?

1. He must be a legally-licensed doctor of medicine. The 1935 Health Officers Law sets up this requirement. This places the entire state health program in the hands of the medical profession, not in the hands of the lawyers or the ministers, or any other group but the medical profession.

2. He must be a leader, since it will fall upon his shoulders to plan and execute his program.

3. He must be possessed of good judgment and imagination.

4. He must be a diplomat in order to sell the desirability of his program to his legislative body.

5. He must be a business man because he will handle large sums of the taxpayer's money.

6. He must have a fundamental knowledge of law, since the very work he is doing is a part of the government of his community.

7. He must be a sanitarian, acquainted with food preparation and sale, milk production and sale, plumbing installation, et cetera.

8. He must be an epidemiologist and disease preventionist.

9. He must be a public speaker.

10. He must be an educator.

11. He must be a capable and efficient office manager. It will fall to his lot to maintain in readily-available form thousands of records, birth certificates, death certificates, et cetera.

12. He must be an executive, since it will fall to his lot to direct all office and other employed personnel.

13. Finally, he must be able to make his living independently of the salary he receives as health officer. It is needless to say that the salary of the Indiana health officer is not even the equal of the starvation wage which we have all heard so bitterly condemned.

### What Are the Duties of a Health Officer?

In discussing the duties of a health officer, it should be pointed out that these duties are the same in a small- or large-sized health department. In the one, the health officer does most of the work; in the other, he is an executive and directs his employed personnel. In either type, however, the health officer is responsible for the success or failure of his office, and it is to him that criticism is directed if the office fails to function efficiently.

### Enumeration of Some of the Duties of the Health Officer

*Duty No. I*—He must be a keeper of vital statistics. In the South Bend Health Department there are now over 100,000 registered births, and over 50,000 registered deaths. These records must be kept in such a way as to be immediately available. A delay of fifteen minutes in obtaining a birth certificate will be cause for complaint.

Vital statistics have scientific value. Morbidity and mortality reports are desirable. The medical profession should know how many deaths cancer causes and what organs are involved, and how many deaths are being caused by the various heart conditions. Are the deaths from tuberculosis occurring in one section of the city, or are they among the Mexican or Negro population? Records of this type should always be available. The health officer and his organization should constantly produce and dispense this information.

*Duty No. II*—He must supervise dog bites. Any dog that has bitten a person should be held under observation by the health officer or his duly authorized agent for ten days. If the dog dies, the head must be sent to the State Board of Health for examination. South Bend had 350 dog bites reported to the health department last year. Twenty-three heads were sent to the state laboratory for examination. Any health officer refusing to fulfill the duties set forth in the law shall be fined not less than five dollars or more than twenty-five dollars. To carry out the provisions of this law requires time and effort on the part of someone.

*Duty No. III*—He must be responsible for rat extermination. If a person, or firm, et cetera, is not willing to exterminate their own rats, then it is the duty of the health department to cause such nuisances to be abated, by exterminating and destroying such rats.

*Duty No. IV*—He must quarantine infectious diseases. The State Board of Health requires quarantine in the following diseases:

| | |
|---|---|
| Anthrax | Tuberculosis |
| Chickenpox | Typhoid fever |
| Diphtheria | Whooping cough |
| German measles | Tularemia |
| Glanders | Undulant fever |
| Hydrophobia | Malaria |
| Influenza | Bacillary dysentery |

* Presented before the meeting of State Health Officers, Indiana State Board of Health, held at the Indiana University Medical Center, Indianapolis, on October 2, 1944.

| | |
|---|---|
| Lethargic encephalitis | Gonorrhea |
| Measles | Chancroid |
| Cerebrospinal meningitis | Syphilis |
| Mumps | Leprosy |
| Ophthalmia neonatorum | Botulinus |
| Poliomyelitis | Asiatic cholera |
| Pneumonia | Bubonic plague |
| Scarlet fever | Typhus fever |
| Smallpox | Yellow fever |
| Tetanus | Vincent's angina |
| Trachoma | |

Our annual report shows that 743 cases of infectious diseases were quarantined during 1943. Not only must quarantine be instituted, but the Board of Health must supply fuel and food in indigent cases.

*Duty No. V*—In discussing communicable diseases, the health officer should carry on a constant campaign to educate people concerning the necessity for disease prevention. Every six months our own health department writes a card to every child who has not had preventive treatment. This card is sent until the child is ten years old.

The parent is told of the seriousness of preventable diseases, and is advised to take the child to his family physician for treatment. If indigent, the department of health supplies the material, and our own doctors give the treatments without charge. We also have 2,790 births per year. Creating records of this nature and sending out the semi-annual card is a job of major proportion. It is needless to say that we receive handsome dividends for our effort.

*Duty No. VI*—He must supervise the production and sale of milk in his health province. Most health officers are not milk sanitarians. The problem of milk control is one of the major problems in the department. Some health officers have felt themselves capable of writing a milk ordinance; others have accepted the model Grade A ordinance. This ordinance is the result of the composite thinking of men who are outstanding in the field of milk production and sale. It is highly recommended by the United States Public Health Service. Our own Grade A ordinance contains 19 sections, consisting of 17 pages of rules and regulations. In addition to this ordinance, the standard code, consisting of 147 pages, becomes a part of our rules and regulations. In this code is included the public health reason for the rule, and an explanation of what constitutes satisfactory compliance with the rule.

Our own health department has five hundred farms to inspect at least four times yearly. By January first of each year, all of the 10,500 milk cows must be tested for tuberculosis, and the record properly filed in our office. There are twenty dairies that we inspect two or three times montly. Millions of gallons of milk are consumed yearly by our city. The glass of milk which a person consumes today is no longer from a single cow. Your glass of milk is the composite product of a hundred or a thousand cows. One diseased cow may contaminate our whole milk supply. Since milk is one of the best media in which germs thrive, it would be easy to have an epidemic of disease start in this way. If anything of this nature were to occur, Mr. Health Officer, you would be held entirely responsible. Incidentally, it might be well to mention that a terrible epidemic of typhoid fever occurred in the north central part of the state during 1943.

*Duty No. VII*—He must supervise the production and sale of food. Here again no doctor is very highly trained in food sanitation. The occurrence of large epidemics of food poisoning in the state in 1943 certainly brings home to the health officer his responsibility in seeing that the food dispensing establishments measure up to certain standards. The writer of this paper helped care for one epidemic of food poisoning, in which sixty-eight people were poisoned by eating contaminated food. Survey of the food-dispensing equipment revealed the fact that five thousand to six thousand people were eating each meal in a cafeteria that was created to accommodate fourteen hundred people. The refrigerator door was propped open throughout the entire day. This condition prevailed in spite of the fact that large halves of beef and other fresh meat were hanging inside the refrigerator. A recording thermometer in the coldest spot showed that the temperature had not been below 60 degrees for days. Meat to be kept must be refrigerated at 40 degrees F., or below. When this trouble occured, the health officer was immediately called out of bed at 2:00 o'clock in the morning to do the duties that he had sworn an oath to do. The general public holds us responsible.

Our own Grade A restaurant ordinance contains 14 sections of rules and regulations. In addition, the accompanying code has 54 pages of public health reasons and explanations of what constitutes satisfactory compliance with these rules. To know this ordinance and code is sufficient work for one man. The assumption of this responsibility is only one of the duties of the health officer.

We have 1,380 food-dispensing establishments in South Bend. The enormity of this program alone can be grasped if you consider what it means to inspect them four times yearly. The health officer is responsible for the execution of this colossal task.

*Duty No. VIII*—He must supervise all plumbing installation. I need only to recall to your memory the terrible amoebic dysentery epidemic that originated in the Congress Hotel, in Chicago, to bring to you the full realization of the importance of proper plumbing. Hundreds of new houses have been built in South Bend during the war emergency. I should hate to think what type of plumbing these houses would have had were it not for our plumbing code. The plumbing code of South Bend has 166 sections, requiring 30 printed pages. It is the health officer's duty to see that the code is prop-

erly enforced. If he fails in his duty he may be found guilty of malfeasance in office.

*Duty No. IX*—He must be responsible for the purity of the city water supply. When four or five people drink water from an old-fashioned well, only four or five people can become sick and die. When 120,000 people drink from a common main, there are 120,000 people who may become sick and die. A large city water supply can be infinitely dangerous to its consumers. The most rigid supervision is necessary. Any trouble that may arise is immediately the responsibility of the health officer and will be laid upon his doorstep.

*Duty No. X*—A recent legislature gave the health officer the responsibility of inspecting old-people's homes. A very comprehensive form, prepared by the Indiana State Board of Health, enumerates the things for which the local health officer is responsible, such as: Is the building properly built? Is the food-dispensing equipment of acceptable type? Is the food itself properly prepared and of acceptable quality? These things he is responsible for, and a health officer will soon find out how quickly he is held so if a fire should start, burning a frame building, where there are ten or twelve improperly-housed, bedridden patients on the second floor. Immediately the health officer would be accused of neglect in performing his duties.

*Duty No. XI*—Most communities care for the indigent venereal-disease sufferer. This little business in our town involves the expenditure of $10,000 annually. From 20,000 to 30,000 treatments are given. Every case must be investigated from a financial viewpoint. He may be indigent today, and making $100 a week tomorrow, so investigation is a difficult problem. If a patient comes regularly for treatment, he is of little trouble. If he is delinquent he must be called in, and if recalcitrant, quarantine must be resorted to. The execution of the quarantine law is one of the sores of the health department. No sooner has quarantine been instituted than habaes corpus proceedings are brought to release the patient. This usually requires one day in court to uphold the quarantine action taken. This is a duty that belongs rightfully to the health officer.

*Duty No. XII*—In combatting tuberculosis in a community, it is certainly the duty of the health department to carry out a program of treatment control and contact investigation. In most cases a family who has tuberculosis will submit without force to any investigation which may be desirable, and most families will follow any regimen of treatment prescribed by a physician. Voluntary submission to case investigation and treatment control is desirable. However, where a lack of willingness to co-operate exists, it becomes the duty of the health department to use its authority to accomplish these results. Quarantine in the home or in an institution may be required. It may be necessary to remove children from the family to protect them from exposure to the disease. Authority of this nature is vested in the health department, and should be administered by that agency of government.

There are 3,250 cases of tuberculosis in our county. Many of these are arrested cases. Out of this group of cases, however, there is sufficient work for a small army. Last year 42 deaths occurred in St. Joseph County. If we ever hope to control or to eradicate tuberculosis, our health department must assume its proper place in the control of tuberculosis. Certainly we have not done this to date.

*Duty No. XIII*—It is the health officer's duty to be interested in housing. The state has enacted an insanitary dwelling law. If a house is unfit for human habitation, it becomes the duty of the health officer to condemn the property. He then must provide shelter for the people whom he causes to vacate the property. This law makes it possible to condemn old houses which some property owners refuse to have repaired, but from which they are willing to collect rent. This, too, is the direct responsibility of the health officer.

*Duty No. XIV*—Our town regulates and licenses tourist camps. The war effort has caused a tremendous increase in population in all of our cities. The trailer is a modern invention that very readily lends itself to transient housing. As was to be expected, a large number of people came into our town, expecting to make their homes in trailer cars.

There is no difference in the sanitary requirements of transient and permanent housing. Sewage must be disposed of through proper sewerage connections. The water supply must be guarded as carefully as in permanent housing. Drainage, plumbing, garbage collection and disposal all must be cared for as in permanent housing. Naturally, the duty of enforcing rules and regulations governing these trailer camps falls to the lot of the health officer.

*Duty No. XV*—In our town the disposal of garbage is handled by the street department. A contract is made whereby a private firm makes regular collections. This plan works fine as long as the firm fulfills its obligation of regular collection, and as long as the people make their garbage available. Allow either of these factors to fail to function and the health department is immediately called into the picture to solve the problem, such as: Why isn't the garbage collected? The garbage cans next door are uncovered; the garbage cans are running over and constitute a fly hazard; the neighbors are throwing their garbage on the lawn, et cetera. Daily, during the summer, our health department answers from thirty to forty complaints concerning the matter of garbage disposal. It is a major task for the health department to see that the garbage is disposed of as it should be.

*Duty No. XVI*—Our health department regulates and controls fumigation with poisonous gas and the use of insecticide for eliminating and controlling insects, vermin, rodents and other pests. To carry out this function we must give examinations to determine the ability of an individual to conduct this type of work. After an applicant has passed his tests in a satisfactory manner, he is licensed. Permits to carry on his work are granted and regular inspections are made. Undoubtedly, this is a health department function; to accomplish this work requires time and personnel.

*Duty No. XVII*—To date I have enumerated only duties of the health officer for which he is responsible directly as a result of his police power. Certainly there are other important functions of the health department. A health department has the obligation of educating the people whom it serves. How can proper dishwashing occur if the health department fails to educate the people doing this kind of work in proper methods of dishwashing? How can disease prevention be accomplished if people are not told what to do? How can milk be properly produced and dispensed if those engaged in this work are not told what to do? A good health department should be constantly engaged in educational projects.

Thus, gentlemen, have I enumerated a few of the responsibilities of a local health department. I could go on indefinitely enumerating other duties and obligations of the health department, but that is not necessary. Permit me to say that the state has issued a 110-page booklet of instructions to health officers. In its content are hundreds of other responsibilities which each one of us by our oath of office swears that we will perform.

### A Glimpse of Our Local Indiana Health Provinces

1. There are 192 health provinces in Indiana.

2. In order to be a health officer in Indiana, the 1935 Health Officers Law requires that you be a duly-licensed practitioner of medicine. This clearly places the responsibility of the health of the community in the hands of the medical profession.

3. There are 7 groups of counties in the southern part of the state that have placed the duties of the health department under the direction of a full-time officer. These district health officers are paid by the state for their services.

4. Indianapolis has a full-time health officer.

5. One hundred ninety health provinces have part-time health officers.

6. The health of a community is its most important asset, yet not one of all the provinces has a proper building to house the activities of the department. If any place at all is provided for the health department, it is usually left-over space which no other agency of government requires for housing. It is usually to be found in the basement near the furnace room, or in the attic next to the bat-infested clock tower. For fear that other agencies of government might take offense at this remark, I hasten to say that this condition is directly the fault of the health department. It is axiomatic to say that it is directly the fault of the medical profession.

7. In Indiana the salaries of health officers are fixed by the 1935 Health Officers Law. These vary from three cents per capita for county health officers to two cents per capita for second, third, fourth, and fifth class cities. Remember the extremely important responsibilities which I have enumerated above. Also remember that every health officer agrees to assume these responsibilities when he takes his job. A city of 25,000 people in our state pays its health officer $500 per year. The greater number of cities of third, fourth, and fifth class have populations of 25,000 or less. The result of this condition is that the health officer either fails to function at all, or that he spends very little effort in doing his job. You may be sure that he it not going to antagonize a very great number of his private patients in promoting new health legislation or enforcing old ones.

It is my contention that the health of the community cannot be so superficially considered. We, as doctors, are held responsible for our community health, and it is our duty to immediately change the present setup of local health administration. Do not think for one minute that the community will not hold us responsible if anything goes wrong!

8. In many health provinces the health officer houses, in his own office, his own health department. Just why this is permitted has always been a question to me. Is the community health so unimportant that it is unnecessary to provide housing for important documents and administrative facilities? Every health officer is responsible for the many duties enumerated above, and many more. It is difficult for me to understand how any doctor can perform these duties with any degree of efficiency in his own office. The whole procedure takes on the appearance of a curbstone real-estate broker. It is my opinion that the medical profession cannot afford to see the health of our community handled so lightly.

### What Can Be Done to Change This Condition in These Health Departments?

1. The most important thing to accomplish is to make the local medical group realize that the health of the local community is its responsibility, and to be sure that there is a health officer who acts as an executive. As such, he can function only if he has proper personnel, and is properly housed and properly equipped to carry on this work. Attic or basement space is not the proper place for a health department. Since we believe in fresh air, why not have the health department in such an atmosphere? In our town we certainly need a building to house our health department. There should be an office for the health officer. There should be a record room. There should be milk and plumbing inspectors' rooms. There should be nurses' quarters.

There should be clinical facilities for the venereal disease program and the tuberculosis clinic. There should be a library room, and finally there should be an assembly room for instruction and educational activity. Do we have this? We do not! We have a health department housed in hopelessly inadequate space. The health officer has no desk from which to direct his force. He even goes one better than this; he has no chair upon which to sit. There is one small room given to the inspectors. Three of them have no desks. The addition of new files will make our space even less than at present. We have no library. We have no nurses' room.

Our venereal disease clinic is housed in the basement of an old building which was found undesirable and inadequate to house other court house functions. If an unfortunate patient has a reaction from the treatment, he must lie on the table until he recovers, or until he is sent home, or to the hospital, or to the undertaker. There are no retiring rooms provided for this type of case. Yet twenty to thirty thousand treatments are given annually. This clinic is located three squares from the health department and is run by remote control—yet if anything goes wrong the health department is held responsible.

Our tuberculosis case finding and contact investigation clinic is six squares away—more remote control. Our public health nurses never come to the health department. We have no space, yet the health officer is their executive and is supposed to guide their program. More remote control!

Finally, we have absolutely no room for the instruction needed to take care of any educational program. We could have used this room for doctors who listened to a course of instruction on the care of infantile paralysis. We had to beg the city for the use of its council chamber. Gentlemen, this is our own fault. Why cannot we have a health department housed in a proper building? The park department in South Bend has a lovely building, and I am glad it has. It shows films there instructing the public how to catch fish. Why does not the health department have such a place to show people how to avoid diphtheria, et cetera?

2. It is my belief that the local health officers should have some kind of a state organization. Certainly, we can see things from the viewpoint of the local health department better than anyone else. No one will bring our problems to the attention of the proper bodies if we don't.

Let me give you an example of what I mean. Why couldn't such a body bring to the attention of our legislature, at the next session, our need for a merit system in our local health departments? The adoption of such a plan would assure capable personnel of continuity in service.

Compare this utopia with the present setup. With every change of administration new and untrained personnel is sent to the health department. The new milk inspectors are usually those who have been able to deliver the greatest amount of votes in the last election. The food inspectors are friends of the political party. It is my contention that jobs that involve the very lives of the people in the community should be filled by men who are capable of doing their work. Also, I feel that they should function without political interference. Remember—the health department is in the hands of the medical profession, and failure to function properly can and is always laid upon its doorstep rather than on the doorstep of the political party in power.

3. For a long time our state health department has advocated full-time health officers. There are 192 part-time health officers in the state. This fact shows how successful they have been in their campaign. It is the contention of the writer that the health department is just as important a governmental function as the legal system or the school system. Our own county has six full-time judges to settle peoples' quarrels.

There are three full-time school superintendents employed by the county school systems. There are three health provinces in our county; therefore we have three health officers. Whereas our judges and school superintendents are all employed on a full-time basis, the three health officers are only employed on a part-time basis. Incidentally, our annual salary is $4,500 per year. Is the health of our community of such insignificant consideration as to cause such a great difference in community evaluation? My own opinion of our respective services is that our health department is just as important a community function as the judicial or the educational function. We, meaning the local medical men, have never sold the community upon the importance of health work. We need full-time health officers, and our medical society (both local and state) should help us get them. And when they are secured, they should be paid a salary that is commensurate with their training and their ability to execute the program which they are required to do.

Before concluding this paper I should like to call to your attention two points of cardinal significance:

> In this paper, with the exception of the treatment of the indigent, venereal disease sufferer, there is no mention of the treatment of disease or the care of the sick. This function is within the province of the private practitioner of medicine and should always be done by the doctor as he sees fit. It would be a mistake to fail to thank the Indiana State Board of Health for the wonderful help which it has extended to us. I am sure Doctor Rice and all the other state officials know how dependent we are upon them. There is seldom a week that problems do not arise. These must be called to the attention of the state department, and this department has always come to our aid in a commendable way. We are thankful for their assistance.

Allow me to conclude this paper with the following observations:

1. That the present setup of a local health department is completely lacking in efficiency.

2. That we are caused to carry on our work in cramped and undesirable quarters.
3. That we should have health department buildings that could properly house our functions and, in addition, serve as educational centers.
4. That the functions of a health officer are of unlimited number and of tremendous importance to the community.
5. That full-time health officers should be in charge of this work.
6. That these men should be properly paid.
7. That the health department is the child of the medical profession, and that this group of men should give needed aid to the health department in establishing itself in the community in such a way that it might function with efficiency and with the degree of dignity which *health*, the most valuable asset a community has, should have.

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## ABSTRACTS

### PENICILLIN FOR TETANUS

"In view of the high mortality of tetanus, even when treated with large doses of tetanus antitoxin, the addition of penicillin is apparently a life-saving measure," Russell Buxton, M.D., and Rachelle Kurman, M.D., Newport News, Virginia, report in *The Journal of the American Medical Association* for January 6. They tell of two patients in whom the disease was well advanced when the combination treatment was started. Both recovered.

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### BUREAUCRATIC MEDICINE

The Governing Council of the American Public Health Association on October 4 adopted a report favoring in effect a federal plan of compulsory health insurance, without consultation with medical and dental leaders of the nation, despite a proposal to do so. This indicates, *The Journal of the American Medical Association* for October 14 declares, the attitude that may be expected of those committed to federal control of all matters in the health field if they should have control of the Washington bureaucracy that would dominate American medicine should their ideas become effective. *The Journal* says:

"At its annual meeting in New York, October 4, the Governing Council of the American Public Health Association adopted a report favoring in effect a federal plan of compulsory health insurance. . . . This report, first prepared by a subcommittee, was approved after several amendments by the association's Committee on Administrative Practice. The proposed medical service would be supported by social insurance, supplemented by general taxation, or by general taxation alone.

"The ratification of the report as amended came after extended debate in which there was opposition to the adoption and publication of the report as a stated policy of the association. Those who opposed pointed out (*a*) that the administration of public health in the United States was by no means so universal or so generally adequate that public health departments in general were ready for this step, (*b*) that before the association placed itself publicly on record in the terms of this report there should be consultation with the most interested professional groups, particularly the American Medical Association and the American Dental Association, and (*c*) that the publication of the subcommittee report, its approval by the Committee on Administrative Practice and the call for adoption in the Governing Council occurred within less than thirty days' elapsed time, although the subcommittee had been working on the report for a year.

"The motion to adopt the report was made at the October 2 meeting of the Governing Council and was extensively debated at that time. Action was postponed until the October 4 meeting. At that time an amendment was offered to the motion to adopt. This amendment called for the Governing Council to receive this portion of the report of the Committee on Administrative Practice, and to refer it to the Executive Board of the American Public Health Association with instructions to confer with the Board of Trustees of the American Medical Association and with the American Dental Association in an attempt to arrive at a statement which these three great professional groups could support. The amendment was lost by a standing vote approximately three to one after a voice vote had left the chair in doubt. The Governing Council then proceeded to vote on a motion to adopt the report; this vote was 49 "Aye" and 14 "No." The opposition to the adoption of the report was led by Drs. Walter A. Bierring, past president of the American Medical Association, Haven Emerson, and W. W. Bauer.

"Now what is the group that adopted this report? Of the 7,493 members of the American Public Health Association 1,571 are Fellows. Only Fellows have a right to vote for governing councilors; the vote is conducted by ballot given to each Fellow when he registers at the meeting; Fellows not in attendance do not have a vote. The Governing Council consists of approximately 100 members, of whom 30 are elected by vote of the Fellows, 10 each year for three-year terms; the rest of the members of the Governing Council hold membership by virtue of being section officers or representatives of affiliated (mostly state) public health associations. Members of the association other than Fellows can vote only on section affairs. The report on compulsory health insurance represents, therefore, the action of the subcommittee which prepared it, the Committee on Administrative Practice which approved it, and the 49 members of the Governing Council who voted in its favor. Here is not a democratic practice in action; here is a shrewdly manipulated performance by full-time public officials, economists, bureaucrats. Most of the names of those on the subcommittee are those of men long committed to federal compulsory sickness insurance and to federal control of all matters in the health field.

"The American Public Health Association has an obvious right to express itself on any subject related to the public health. The rejection by the majority group of the proposal for consultation with medical and dental leaders indicates the attitude that may be expected of them if they should have control of the Washington bureaucracy that would dominate American medicine should their ideas become effective. Perhaps this step in which these men had leadership will be useful in serving notice once more on the medical, dental, nursing, pharmaceutical and other professional groups as to the nature of the political manipulators in the fields of social security and public health whom the medical professions will be forced to combat."

*THE JOURNAL*
OF THE
INDIANA STATE MEDICAL ASSOCIATION
DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA
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# Editorials

## THE 1945 GENERAL ASSEMBLY

Comes again the biennial session of the Indiana legislature, a period always of much interest to the medical profession of our state. This year, after several concerted attacks on our profession, throughout the country, our job becomes a real one—that of presenting to the people of Indiana, as well as the one hundred fifty members of the legislature, our policy, which is that of making public health the great factor in all that is done.

Physicians of Indiana have had due notice of the importance of having a set, definite program. Our legislative committee long has been at work on this, and has adopted a straight-forward program, of which all county medical societies have had ample notice. They have asked few favors, chief of which is that each county send in a report as to the status of the members of the legislature from that county.

*As of January sixth, less than half of our county societies have responded with this information.* This is not a heavy task, that of compiling the information asked; it is a matter of *organization.* All county groups have—or should have—a legislative committee. If the committee in *your* county fails to function, scrap it and appoint a new committee of live wires.

Every Indiana physician who reads THE JOURNAL must know of the seriousness of the situation confronting us; they must know that strong steps are being taken, looking forward to the final regimentation of the profession; they must know that plans are being made to sap the medical practice act of the State of Indiana.

They also must know that we of the Indiana State Medical Association are asking for a change in that Medical Practice Act, the basic law under which we are now operating—a change made necessary by the fact that certain schools of medicine no longer exist.

We cannot get this needed legislation by merely asking for it; we must show the legislators that there is a need for such legislation. At the same time, we cannot forestall legislation inimical to our interests merely by stating that we do not like it; we must advance sufficient good reason for not liking it.

Generally speaking, legislators are men and women of sound judgment; there are a few, of course, who ever look at the political effect of their votes. But it is our opinion, borne out by several years of experience in talking to members of the legislature, that these folk will listen to sound, common-sense argument. Most of them want to know the why of things.

Your Association legislative committee spends a lot of time on their program. They spend a lot of days in going about the state, trying to awaken the doctors of Indiana to the perils that confront them. When they ask a county group for information regarding legislators from that section, they are entitled to an immediate response.

Legislators are known, personally, to members of the medical profession in their home territory. Many members of the profession serve as family physicians to the legislators, and who is better qualified to sit down and talk to them than their family doctor?

It is of especial importance that contact should be made, at home, with members of the Public Health Committee of the Senate and the House. These are the men to whom health bills are referred, and their report has much to do with the final action on such bills.

What Indiana Medicine needs, right now, is a shot in the arm—a shot that will rejuvenate us and arouse us from our lethargy. Four thousand doctors can wield a whale of a lot of influence in legislative matters—let's get going, and keep on going!

## WASHINGTON CRACKS DOWN

The expected has happened; official Washington, after long consideration, has issued some ultimatums that affect every citizen of the country. The first edict was that horse racing will be taboo for the duration, and immediately following that came the announcement that many other items were in the same order.

Of chief interest to us, as medical men, is the order that conventions, too, are out, save by special dispensation. Just a few minutes ago we were officially advised by Olin West, secretary and gen-

eral manager of the American Medical Association, that the annual meeting of the Association, scheduled for June, in Philadelphia, had been called off. To many this was expected, since official Washington had made it clear that transportation problems were such—and they probably will become more intricate—that conventions would have to go by the board for some time to come.

Most of us have been of the firm belief that medical conventions are necessary. They furnish one of the chief means by which professional ideas are exchanged; they serve, for many of the profession, as postgraduate courses. They are, of course, largely attended. In former years the social phases of these meetings were not overlooked; we had our golf tournaments and whatnot; we had our annual get-togethers, dignified by the term "smokers"; we had our annual banquets, and we had our auxiliary meetings and entertainments. Of later years, however, the social side was generally relegated to the past. Our conventions were strictly business, with the House of Delegates, Council, et cetera, providing the business aspects of the profession.

Even so, we now face a problem—whether or not to ask for a special dispensation to hold our annual meetings. There are many arguments on both sides of the question. We deem it vitally necessary to hold some sort of a session where we can transact the business essential to the carrying on of our organization work, and we need the interchange of medical thought.

On the other hand, at a time when the entire medical profession of the nation is being attacked by those who would break us down, the question arises, can we afford to furnish further ammunition for those who are fighting us? We believe that we will be permitted to hold business meetings, and that we may carry on the program we have outlined for many years; beyond this it is, as we have said, a serious question.

As we read the ruling, a convention of more than fifty is taboo; this would not enable most states to hold a meeting of their House of Delegates, except by special permission. It is, of course, possible that before this is published there will be sent out further rulings, some of which may clarify the picture.

Other parts of the ruling are also of interest to physicians; the suggestion that home and office heat be maintained at not more than 68 degrees at once becomes a problem. We are all familiar with hundreds of cases in which such a temperature is out of the question, both in the offices and in the homes. Elderly folk, invalids, and babies certainly require a warmer atmosphere, and in many offices where examination "in the raw" are made the same conditions apply.

We can, of course, get along without the shop windows being illuminated; we can get along without so much lighting display in front of our movie theaters; we do not need to make a "Great White Way" out of our city streets, and we can get along with less train and automobile travel.

The vacation problem now becomes most acute; we are advised that "resort special" no longer will be operated, and that in some cases trains with a minimum of patronage will be annulled. And we still are of the opinion that vacations for most folk—medical folk in particular—are vitally necessary, but the problem of where to go and how to get there is now one that requires a lot of ingenuity in its solution. Our prediction is that near-by spots will be filled up this summer, as never before; we will get intimately acquainted with what Indiana has to offer as a vacation land.

So we face another problem, and our medical leaders—the heads of our medical organizations—have a big job ahead of them. We trust that they will come up with the proper solution.

Frankly, we long have felt that the American people have had things pretty easy during these times of World War; we have not felt the pinch as have peoples of other nations, so it may be just as well that we will have to forego this and that for some time to come.

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## CONCERNING THE EMIC PROGRAM

At the recent meeting of the medical society secretaries and editors, at the American Medical Association Building, at Chicago, there was considerable discussion of the difficulties inherent in the administration of the EMIC Program. THE JOURNAL wishes to take this occasion to say that the medical profession is now and always has been a very patriotic organization, and therefore is willing and glad to do anything possible for our servicemen. After all, most of us have boys or girls in the service, and naturally we would wish to do well by them. Furthermore, we wish to point out that the best friend of mothers and children has always been the family physician.

The effort on the part of Congress to help out the boys who are in service, and who had wives back home, was undoubtedly sincere, and this measure by which at various times they have created funds for the EMIC Program passed the House and the Senate each time without a single dissenting vote. We wish to assure members of Congress that as a profession we heartily endorse this program. There is, however, a great deal of difficulty in administering the program. We believe that this is most unfortunate, and that it could have been prevented if the whole thing had been set up in a somewhat different way. As a matter of fact, the Act of Congress which appropriates money for this purpose is an extremely simple Act in itself. It is hardly capable of misinterpretation. There is one sentence in this Act to which we should like to call attention:

". . . to provide, in addition to similar services otherwise available, medical, nursing and hospital,

maternity and infant care for wives and infants of enlisted men of the fourth, fifth, sixth, and seventh grades in the armed forces of the United States, *under allotments by the Secretary of Labor and plans developed and administered by State Health Agencies and approved by the Chief of the Children's Bureau. . . .*"

We wish, respectfully, to call attention to the *underscored* portion of the above provision. It would seem from this that it was clearly intended by Congress that the plans be *developed and administered by State Health Agencies.* These plans are, of course, to be approved by the Chief of the Children's Bureau before allotments from the Secretary of Labor can be provided. As a matter of fact, all, or nearly all, of the states offered plans for this program. These plans were turned down by the Children's Bureau, and then the Children's Bureau provided plans which the states were expected to approve if they got the money. This is an *exact reversal* of the instructions of Congress. Plans made on a national basis are too inflexible for good administration, and much misunderstanding has resulted.

When difficulties in administration have come up and complaints were made to congressmen there has been a tendency to lay the blame on the state boards of health, when it really should be laid in large measure to the Children's Bureau. We insist that it was the evident intention of Congress that the plans *originate* in the states. In such case any plans in conformity with the intent of the Congressional Act should be approved by the Children's Bureau. Nearly all of the difficulties in administration could be solved if this were done. The Children's Bureau has usurped powers not intended for it, and which clearly belong to the boards of health of the respective states.

## PETER IRVING, M.D.

Of the medical men who have been attending national medical gatherings there are few who did not know Peter Irving, a direct descendent of Washington Irving, who died in the Roosevelt Hospital, New York, on December twenty-eighth. For the past few years he had served as secretary and general manager of the New York State Medical Society, and as managing editor of the journal of that organization.

He was born in Wisconsin, was educated in New York schools, and had practiced internal medicine for many years before taking up his secretarial work.

He was an indefatigable worker, his efforts being directed toward medical organization. In 1941-42, when medical men were asked to take over the Procurement and Assignment Service, he took charge of the New York state organization and brought complete order out of a somewhat chaotic condition.

As the *New York State Journal of Medicine* wrote it, "He literally wore himself out in the service of the society. He had few other interests than those of his fellow physicians of the state, whose unfailing friend and loyal servant he was."

It will be a long time before his state society will find a man who can take his place, for there are but few medical men who will sacrifice *everything*, as did Peter Irving, to further the cause of medicine.

We have noted this man in many medical gatherings; he was quiet and reserved, never wishing to do a lot of talking, but always on the *qui vive.* He had a vast store of information about medical affairs, and knew most of the answers.

We share with the New York State Medical Society in their loss of this great and good man.

## "DEBUNKING THE VITAMINS"

On November twenty-seventh the *New York Times* gave editorial space to the subject of vitamins, and with their permission we are reprinting it in THE JOURNAL:

"Forty years ago we were told that the body is nothing but a living boiler plant and engine which had to be stoked with fuel in the form of food that contained enough energy. So we became enamored of calories. When the deficiency diseases were interpreted by the nutrition experts, we learned that although tables might groan with calories, we could starve to death. So we turned to vitamins. They are now the largest item in drug store sales. We consume them almost as freely as if they were candy, whether we need them or not. There is no doubt that we need vitamins. But is the need always real? Not if we are in good health and remain so by eating the right food, according to a report by Drs. Julian Ruffin and David Cayer, of Duke University, in *The Journal of the American Medical Association.*

"For thirty days volunteer students consumed the usual American diet. Daily records of well-being were kept. No student knew what he was receiving or to what group he belonged, although all were told that some were to be given sugar pills and the rest vitamins. There was no striking difference in the records of all groups. Accordingly, Drs. Ruffin and Cayer wonder 'if the indiscriminate use of vitamins, sold over the counter to people who have no obvious disease, is justified.'

"Cautious nutrition experts have been preaching the same doctrine of late, and it is about time that the vitamin eaters pay attention. Whether or not there are symptoms of a deficiency disease the physician must decide. Evidence recently presented by Dr. Tom Spies, of the University of Cincinnati, indicates that even the physician too often flies to the vitamin bottle for no good medical reason. What we need are simpler laboratory tests for deficiencies than those we have—so simple that they can be carried out by any physician in his office or by any diagnostic laboratory at low cost to the patient. Give us this, and the doctor will be able to prescribe vitamins where they are needed with more certainty of benefits to come than there is now."

Some two years ago several suggestions were sent in, asking that THE JOURNAL publish an editorial on this subject, one southern Indiana member even suggesting a title, the same as used by the New York editor. After some discussion it was decided not to "pioneer" in this subject, rather to

await such a time as some other publication took it up.

In *The Journal of the American Medical Association* for November twenty-fifth appeared an article on the subject of the indiscriminate use of vitamins, and it was this article that formed the basis for the *Times* editor.

In our opinion, this vitamin thing is grossly overdone; it has just about gotten away from sensible medical control. The radio blares "facts about vitamins," the announcer reading from script prepared by a manufacturer who all too often is not even engaged in the manufacture of medicinal products. Witness the recent purchase of a vitamin-making laboratory by one of our large soap manufacturers. Even the chain groceries have vitamins for sale and do a lot of talking about them.

Some of these compounds are of the "gun-shot" variety; they contain numerous vitamins, in the hope that some one or two of them will do some good. There is, of course, a definite vitamin therapy, but it also definitely is not within the province of laymen to determine what vitamins shall be used, and when.

It would seem that here is a new field for the Pure Food and Drug agencies, the Fair Trade Commission, and others to work in, and bring some sense of order out of the present vitamin chaos.

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# Editorial Notes

Dr. N. K. Forster, president of the Indiana State Medical Association, hands out the following suggestion, which if followed by every physician in the country would in no time settle many of our present problems: "Think and act straight, because the future of American Medicine, for many years to come, depends upon our course." Better re-read that statement and *fix* it in your mind.

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The *Muncie Star*, commenting on a report by Surgeon General Kirk, of the Army, says, "Under conditions which prevailed in 1918, sixty thousand wounded soldiers would not be alive today, and many more would have been crippled for life. The Army's death rate would have been twenty times what it is, and malaria would not have been reduced 75 per cent."

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According to a newspaper report, an eastern physician has hit upon a novel plan of entertaining patrons who have to await their turn in his office. Instead of thumbing over ancient copies of magazines, these patients witness a movie, right there in the office. The doctor is said to get two reels each week, and while the reels are being changed the "guests" are entertained with a radio program.

Our capital city, Indianapolis, is planning a preventive medicine setup, with Dr. Gerald Kempf at its head. Dr. Kempf has had extensive training in the Lilly Clinic, at the Indianapolis City Hospital, and is eminently qualified to head such an important division of the City Health Department.

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Just as we have overcome the fear of psittacosis —parrot disease, you know—along comes an article in *The Journal of the American Medical Association* about ornithosis—pigeon disease. Better lookout next time you are in Indianapolis, for this city long has been known as the pigeons' heaven.

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Among the many illnesses to which the human body is subject, there are at least four that are all too common and that may be regarded as being among the incurables. According to a recent statement by Dr. Morris Fishbein, he lists cancer, infantile paralysis, rheumatic fever, and multiple sclerosis as the "four big foes."

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The story going around, to the effect that the American Red Cross is *selling* blood plasma to the Army, is, of course, pure fabrication. This statement has had its chief circulation among soldiers and sailors within the United States, says Chairman Basil O'Connor. As a matter of fact, the blood that is donated by the citizens of this country, to the extent of 100,000 donors each week, is at once turned over to the Army without price of any kind. Should you hear any such rumor, it is your duty to make a positive denial at once. The American Red Cross recently has added another to its many activities, this time in behalf of school children of stricken countries. Medicine sufficient for treating one million school children has been sent to Yugoslavia, Greece, and Belgium by this organization, which has spent the sum of $87,500.00 for this purpose. Further, forty-four tons of drugs have been sent to China via airplane.

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It seems that the open season for grafters of all sorts is again with us, solicitations via the mails being about as numerous as they were some years ago. One of the offending outfits is mailing miniature "license tags" to motorists throughout the country, asking a small donation in return. They claim to be doing this for the "Disabled American Veterans." We would again remind our folk that they are under no obligation to answer such requests, nor to return anything that has been mailed to them without an express order. The quickest way to break up this racket is to forget about the whole thing, even though follow-up requests come from the sender.

A few years ago a Buffalo concern mailed neckties all over the country, without order, and finally gave it up as a bad job after the recipients had been advised that they were not obligated to do anything about it.

Stephen Pencheff, Indianapolis chiropractor and naturopath, wrote the *Indianapolis News* Vox Pop department concerning the action of Governor Schricker in naming December fifteenth as the "Bill of Rights Day." He said that he hoped the Bill of Rights will be applied to the securing of "rights" for the drugless healers, who are demanding entree into our hospitals, both public and private.

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Lowell Nussbaum, of the *Indianapolis Times* "inside Indianapolis expert," tells about an Indianapolis E.E.N.T. physician who received a letter from a fellow physician now located in Brazil, South America. He had written his confrere, going to the trouble of getting someone to write the letter in Spanish. The answer, however, was written in the Portuguese language, and our Indianapolis friend had one heck of a time trying to get someone to interpret it for him.

Our son, Doctor Jim, had spent more than two years in southern Texas and had picked up quite a smattering of Spanish while down there. When he was transferred to Sao Luiz—pronounced Say Louise—he thought this would come in good stead. However, he found that Portuguese is the official tongue of Brazil, so now he has to start learning a new language.

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Hopkins and Fadget, in *The Journal of the American Medical Association* of December ninth, present a factual and very informative report on leprosy in this country, they being connected with the Leprosarium, at Carville, Louisiana. Many physicians are of the opinion that leprosy is a rare disease in this country, while as a matter of fact it is not at all uncommon in many sections of the country. During the past fifteen years some 723 patients have been admitted into this institution, and in that period about twenty per cent have been conditionally released and declared to be no longer a health menace, which surely is a good record. Sixteen patients declared to be ready for release have chosen to remain in the colony for various reasons, chief of which is the difficulty in supporting themselves.

Formerly the greater percentage of cases came from Louisiana, but now a greater number come from Texas, where the disease seems to be on the increase. About 72 per cent of the foreign-born patients were of Mexican, Philippine, Chinese, and British West Indies nationalities. Sporadic cases have come in from other states, even some states in the northern section. The authors are of the opinion, however, that the incidence of leprosy in the United States will not be materially increased because of war conditions. In other than the Negro race, the far greater percentage of cases occurred in the male population. Of the 723 cases admitted in the fifteen-year period, there were 190 deaths; however, the chief causes of death were nephritis and tuberculosis, very few such deaths being attributed to leprosy as the primary cause.

We are reliably informed that Labor plans to introduce "State Health Insurance Bills" in possibly eight states, and that Michigan and California have been chosen as "testing grounds." The refusal of the Congress to increase payroll deduction taxes might appear to have a deterrent effect on some of this legislation, for without this increase there could be no program, as has been proposed. But it will be well to remember that the President has something to say about such matters, and it is possible that by applying the lash he may be able to get such an increase through the Congressional hopper. All this may be regarded as but straws in the wind, but please remember that they are big, tall, healthy straws, and that when the wind blows in the right direction—then what? Our eyes and ears must be ever alert these days. We have a whale of a job before us; we cannot let down even a little bit.

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What could be a higher tribute than that paid to the medical profession by the *Evansville Courier*, of November 22, 1944, in an editorial entitled "Saga of Miracles," a copy of which was sent to us by a former member of our Editorial Board, and which we take the liberty to reprint herewith:

"American military surgical and medical care in this war has attained a level of efficiency unparalleled in the world's history. Skill and science combined have produced results so truly marvelous in efficacy as deservedly to be called a 'saga of miracles.'

"Although the public has heard from time to time about the marvels being performed, the most comprehensive picture so far is furnished by the reports presented before the Association of Military Surgeons. There is, for instance, the fact of the Navy's wounded at Normandy, 99 out of 100 of those who recovered from their injuries returned to duty. At Saipan less than 1 per cent of the cases reaching the operating room have proved fatal.

"No less impressive is that of the Navy's total wounded to date, only 2.3 per cent have died as compared to the 8 per cent in World War I. And from Army hospitals in this country wounded men fully recovered are being returned to duty at the rate of 12,000 a week. This is after a little more than a year's experience in what is termed 'operation reconditioning.'

"There are many reasons for this record. Thousands owe their lives to blood plasma in combating shock. Other thousands have been saved by sulfa drugs in eliminating the dangers of infection. These remedies were unknown in World War I. Through routine injections of serum, tetanus, which was the scourage of all armies, has practically disappeared.

"Under the new technique of organization the military medicos are subject to great perils, but the whole setup is directed to insuring prompt emergency treatment for the wounded where they fall, and then getting them quickly hospitalized. As a result, according to the Army's surgeon general, 60,000 American soldiers, who would not have survived their wounds had they received them in World War I, are alive, and 9,000, who would have been left hopeless cripples for life, have been restored to normal activity.

"A wonderful record is being written, one that reflects the highest credit upon the doctors, nurses, technicians and enlisted men composing the medical and hospital detachments of the nation's armed forces. The country honors them for their competency and courage."

Only a few months ago many medical men felt that the Wagner-Murray-Dingell Bill was a dead duck, that no longer would we have this spectre dangling before us. But since then we have had a national election; each of these three members of the Congress are still with us and more than ever determined to do things. In fact, all three of them are more peeved with us than ever before. Represenative Dingell, in a radio address the night before the election, is said to have stated, among other things, that there had been a well-financed campaign against this bill "by a group of medical mossbacks of the American Medical Association." The *Congressional Record* carries statements that frequent demands are being made that this bill come out of the committee, while its three authors are prepared to re-introduce the measure, probably with some changes. It also is anticipated that the bill, as it now stands, will be split into sections, in the hope that this may facilitate action thereon. Senator Pepper, of Florida, rather strongly intimates that he, too, may offer a bill somewhat along the same lines.

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American Medicine lost one of its real assets in the passing of Dr. George E. Follansbee, of Cleveland, on January first. It is given to but few men to serve organized medicine as did Doctor Follansbee; he *believed* in his profession and, while a busy surgeon, always managed to find time to further the interests of the profession. He was chief surgeon for the old Grasselli Chemical Company, later taken over by the DuPont interests. In 1906 he became a member of the staff of St. Alexis Hospital, at Cleveland, and later served as chief surgeon of that institution until his death. In 1940 he was made an honorary member of the Cleveland Academy of Medicine, in which he had for many years been an active figure. For some twelve years he served as a delegate to the American Medical Association, and for more than fifteen years he was a member of the Judicial Council of that organization, most of that time as chairman. He was an indefatigable worker, not only in his private practice as a surgeon but in the many medical organizations to which he belonged. His chief hobby, if there was one, was a study of the early explorations of North America, and his collection of the records of the Hudson Bay Company was regarded as the best extant. The memory of Dr. George E. Follansbee will be a part of the record covering the best phases of American Medicine.

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In commenting on the appointment of Dr. Robert R. Hannon as successor to Dr. Joseph Lawrence (now head of the Washington office of the American Medical Association), the *New York State Journal of Medicine*, of January 1, takes occasion to remark:

"It is our considered opinion that American Medicine, both to fulfill its wartime functions and to exercise its full scope and power in the postwar world, will need to develop further a quality to which it had not yet sufficiently directed its full attention; namely, the quality of medical leadership.

"Medicine's relations with local, state, and national government, and with the projected supergovernment of the future world will be vast, complicated, intricate, and can be properly and powerfully influential. It can aid, perhaps as no other agency yet created by mankind, in the cause of maintenance of the peace; it speaks all languages, crosses all borders, flies to the stratosphere, goes underseas, and enters all homes and hearts. . . . Our concept of the teaching of medicine has been somewhat limited by our closeness to it. Our concept of the practice of medicine has been too circumscribed in the past, by what we thought were the limitations of the practitioners. Our relations with each other, with the public, and with agencies of the government have been erratically timid, sometimes querulous, often diffident, frequently formidable. There does not seem to have been developed, as there could have been, a quality of leadership, either by our schools, our county societies, or our other representative bodies, which could be thought of and respected as consistent medical statemanship."

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## ABSTRACT

### PENICILLIN FOR EMPYEMA

Penicillin, administered by injection into a muscle for one week before and for two weeks after the partial or total surgical removal of the lung, appears to be useful in preventing pyogenic infections following the operation, nine Philadelphia investigators report in *The Journal of the American Medical Association* for December 16. Their report is based on results obtained in a study of forty-one patients, twenty-one of whom received the penicillin treatment and twenty of whom served as controls.

The report is made by William L. White, M.D.; W. Emory Burnett, M.D.; Charles P. Bailey, M.D.; George P. Rosemond, M.D.; Charles W. Norris, M.D.; Grant O. Favorite, M.D.; Earl H. Spaulding, Ph.D.; Amedeo Bondi, Jr., Ph.D., and Russell Fowler.

None of the patients receiving penicillin prophylactically showed evidence of empyema, the investigators say, while twelve, or 60 per cent, of the controls developed pus in the pleural or chest cavity. Patients with pus-producing lung infections who had part or all of the lung removed, and who received the penicillin, not only showed no evidence of postoperative infection but also had less fever, were allowed out of bed earlier, and were discharged sooner than control patients. No toxic reactions were noted in the penicillin patients.

# President's Page

## PUTTING UP A FRONT

It has been said that confession is good for the soul; it also frequently relieves the mind. We have before us a "digest of the minutes of the East Central Regional Conference of the Council on Medical Service and Public Relations." We must confess that the score up to now is 0 to 0—nothing for Medical Service and nothing for Public Relations.

At the request of the American Medical Association, we have formed our own Council on Medical Service and Public Relations to cooperate, in every way possible, with the parent organization. This was evident when eighteen of our members made an inconvenient trip to Cincinnati to lend their efforts to the success of the meeting. It left us cold. Frankly and outspokenly—if this Council is to be nothing more than a fact-finding and advisory body, then the whole purpose for the institution of this Council is already defeated.

We anticipated that the organization of a Washington office would have, primarily, the effect of instigating active, progressive measures for combating the ill-advised and wrongfully informed men and women in Washington who for political, or other reasons, have been pressing for a change in the type of medical practice.

Well, we have a new Wagner-Murray-Dingell Bill in the offing. We have a contemplated Pepper plan for medical reorganization. We have a United States Public Health Service plan ready for consideration. We have a plan formulated by the old Committee of 430 under a new name. Another plan is suggested by the American Public Health Association, also other plans under consideration for the Veterans' Administration Facility. Undoubtedly, the labor unions also have their own ideas regarding measures to broaden medical care.

Everybody seems to have a plan except the American Medical Association.

The one thing not mentioned in the "digest of minutes" referred to above was the fact that upon motion a poll was taken to disclose the attitude of the men present as to whether the Council should take active leadership, in not only disclosing facts but in making definite recommendations for immediate action on the part of the various state organizations concerning their welfare. This was agreed to almost unanimously. We look to this Council for aggressive action, and to the Washington office for a well-planned offensive that will bring results. It's too late now to quibble about the term "lobbying"—we need action—a lot of it. Maybe it is late, but it is not too late to try.

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# DESTINY CALLS OUR YOUTH

MRS. MARY YORK

President, Indiana State Nurses Association

INDIANAPOLIS

From our wounded on the battlefield comes an urgent appeal for nursing service, and in this crisis the nurse has a destiny to fulfill. Only the young and healthy nurse can render this service, so on her falls a responsibility and a privilege to answer the country's call.

As so well stated by Lieutenant Colonel Mildred P. Carter, the general public, hospitals, and other organizations who employ nurses have an obligation to the American soldier to see that nurses are provided to do the task. Yes, sacrifices will be necessary, for no nurse must be used in civilian employment who is needed for the armed forces.

Our casualties are mounting and our men deserve the best that American nursing can give. Nurses of the highest efficiency, in good health, and within the age range are required, and the nurses who meet these requirements must be provided at once.

More than 75,000 nurses have already volunteered for service with the fighting forces. That is a large proportion of a profession that has only about 265,000 active members, especially when the call to duty on the home front is also tremendously strong. Of the 75,000, an average of one out of six failed to meet the physical requirements.

Public cooperation all along the line is needed. The citizens of Indiana must cut down their demands upon the nursing profession during this emergency. Our boys wounded in battle cannot wait. The military need is now. Everything else in nursing is secondary. A nation at war must give first thought to its battle-injured. We must find a way to care for the sick at home after the Army and Navy demands for nurses have been filled.

Indiana has a quota of 312, the minimum number of nurses needed by the military by July first. However, it is hoped that this quota may be reached by April first, for it is reasonable to believe that more emergency calls for nurses will be forthcoming.

In Indiana, there are approximately 650 nurses classified as 1A by the Indiana Procurement and Assignment Service for Nurses. They are classified as being in non-essential nursing service. In all fairness, the military looks to this group for enlistments. Those who for very definite reasons cannot go should by all means enter essential nursing in order to release others who might enlist. There should be no nurses in non-essential service in Indiana.

The doctors, too, have an opportunity to render a valuable service in this present emergency, a service which no other profession or group could render.

First, the doctor can help by encouraging the 1A nurse to enter the military. Second, the doctor can encourage the retired graduate, registered nurses whom he knows, to return to duty on the home front. And third, the doctor can interpret to the community the reasons for the shortage of nursing service.

The thousands of nurses already in the armed forces, the greater number of whom are outside the United States, have done a wonderful job. They have made the public realize that the members of the nursing profession are women of whom all America can be proud. But as patriotic as they are, they cannot continue their task without more help.

The call is for 10,000 more nurses. Everyone must help in the recruitment, for the care of our wounded boys is at stake. Those boys are saving our nation. Let us save them!

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# NURSES NEEDED TO CARE FOR COMBAT CASUALTIES

MRS. G. D. FRENCH

Chairman, Red Cross Nurse Recruitment Committee

INDIANAPOLIS

A minimum of 312 nurses must be recruited from Indiana by June thirtieth in order to meet the needs of the Army and Navy Nurse Corps. Approximately 20,000 nurses are needed, one-half of them immediately. Recruiting authorities have been asked to secure 233 of the 312 nurses from Indiana by April first.

There is now conclusive evidence that the requests of the Army and Navy are very urgent. Hospitals, both overseas and in this country, are not now adequately staffed with graduate nurses. With heavy casualties just beginning to roll in, unless there are more trained nurses recruited, wounded soldiers, sailors, and marines will suffer, and many of them may make the supreme sacrifice because of lack of adequate nursing care.

The situation is so acute that it has been necessary for the President to ask Congress to draft

nurses for the Army and Navy Nurse Corps. Legislation already has been introduced which provides that nurses will be inducted as privates. If a nurse volunteers in the Army, she enters as a second lieutenant; in the Navy she enters as an ensign.

Colonel Florence Blanchfield, superintendent of the Army Nurse Corps, has characterized the need for nurses in the following words:

> "We have been telling the nurses and the public of the need for three years, but up until August we have not put so much emphasis on the *must*. Now, we not only need 10,000 more nurses, but we *must* have them.
>
> "Campaigns in Europe got under way in June, and the picture is entirely changed because of the greatly-increased load of casualties. However, up until December we were able to meet all demands for overseas units and keep an adequate staff at home. This was true, partially, because we were using Senior Cadets, Red Cross Nurse's Aides, both paid and volunteer, civilian nurses, and WAC technicians in the hospitals in this country."

For the first time since the war began, this country is feeling the effects of all-out campaigns on all fronts. War casualties were occurring in November and December at a rate of 300 per cent greater than in July, and have increased at an average of 12,000 a week. In order not to sacrifice the life of a single man at the front, the Army Medical Department is stripping hospital installations in this country of nurses, so that they can serve overseas where the need is so urgent. Of the 41,000 nurses in the Army, about 75 per cent are overseas. But even such extreme measures have not been enough. In December medical units which were activated far in advance of scheduled shipments had to sail without nurses. That means that staffs of already-overworked hospitals overseas will have to be spread thinner, in order that nurses may be provided for the new units.

In this country, too, the shortage is apparent. Ships and planes brought more casualties to this country for hospitalization during September than were evacuated during the entire preceding thirty-two months.

At Wakeman General Hospital, the second week in January of this year, there were over 2,000 wounded men, most of them from battlefronts from all over the world, and only 52 graduate nurses. Forty Red Cross Nurse's Aides are working there on a volunteer basis, serving two-week periods at a time. At Wakeman and other military hospitals the Army has employed Red Cross Nurse's Aides, calling them Army Nurse's Aides. A large group of WACS is receiving training as technicians at Wakeman, and are being used there and in other hospitals to supplement the work of the graduate nurses.

Both Wakeman and Billings General Hospitals are employing, and will continue to employ, graduate nurses on a civilian basis—so acute is the need for expert nursing care.

At Billings, the first week in January, there were 100 more casualties than the rated hospital capacity. Wounded men are taking over space that had not been set up for hospital service.

All groups interested in the Nursing Service are cooperating in Indiana to see that the quota requested by the Army and Navy is met. The state and local Nurses Procurement and Assignment Committees have classified enough nurses as non-essential to the home front to meet the quotas requested by the Army and Navy. Consequently, civilian front nursing care should not suffer greatly.

It may be necessary because some of the nurses classified as 1A (non-essential to the home front) are not eligible for the Army and Navy Nurse Corps, because of failure to meet physical qualifications, overage, or because they are mothers of minor children, to place other nurses in class 1A and return those presently listed as 1A to essential civilian classifications.

Everyone is agreed now that the needs of the Army and Navy come first, in order that those who are fighting our country's battles will have priority on expert nursing care. Nursing leaders are hopeful that quotas will be promptly met in all states so that the proposed draft will not be necessary.

## INDIANA IS PROUD OF ITS COVER GIRL

And rightfully so! The photograph used on the cover page is that of Ensign Sarah Kathryn Liebermann, who graduated from St. Vincent's Hospital School of Nursing, in Indianapolis, in August, 1943. She entered the Navy in December, 1943, and was first assigned to the hospital at the Great Lakes Naval Training Station, at Great Lakes, Illinois, where she remained seven months. She was recently transferred to the Naval Hospital at Corona, California; possibly her next move will be overseas.

Ensign Liebermann is the daughter of Mr. and Mrs. Frank Liebermann, of Vincennes, Indiana. The service flag in the Liebermann home boasts five stars—one for their only daughter, and four for their sons, Lieutenant Francis, of the Marine Corps; Lieutenant Robert, Sergeant John, and Sergeant Joseph, all of the Army Air Corps. The Liebermanns deserve much praise for their patriotic service.

Ensign Liebermann answered her country's call for nursing service in the armed forces, but the need for more nurses is now greater than ever before. From our wounded on the battlefield comes an urgent call for nursing service, and in this crisis the nurse has a destiny to fulfill. An appeal is made to all young, graduate nurses to enlist at once in the armed forces.

# SUGGESTED PLANS FOR THE DEVELOPMENT OF PUBLIC HEALTH IN INDIANA

THURMAN B. RICE, M.D.

Acting State Health Commissioner

Indiana State Board of Health

INDIANAPOLIS

ITEM I—*The codification of the health laws.* It is generally agreed that the health laws of Indiana should be codified so that they would be more accessible to the public and to those who may need to administer these laws. This code would be of great value to health officers, local officials of various kinds, to restaurant operators, property owners, and such other people as may need to understand the health law of their state. The formulation of such a code will also give opportunity to bring our health laws up to date and to correct many faults in the laws which have accumulated by accretion over a period of eighty years.

It is generally agreed that this is a very valuable undertaking, and at this time I wish merely to suggest that the Codifying Board might well consist of two senators, one from each of the major parties, appointed by the governor or the lieutenant-governor, as he may see fit to recommend; two representatives appointed either by the governor or the speaker of the house of representatives, as he may recommend; and three other members who shall serve *ex-officio,* they being the attorney general, the director of the Legislative Reference Bureau, and the secretary of the State Board of Health. The members of the board would, of course, have the power to deputize other persons to help them with the preparation of the details of the bill.

It will obviously be necessary that there be certain funds available for the pursuit of this work. For example, the four members of the board who belong to the legislature should be paid ten dollars per diem, plus their traveling expenses for the days that they actually serve in this work. Furthermore, it may be necessary to employ other expert assistants. Estimates as to the sum needed are not available at this moment.

I recommend, too, that the State Board of Health, the Attorney General's Office, and the Legislative Reference Bureau be authorized to expend their own funds and use their staffs in the furtherance of this work, if such should be needed.

This code is to be offered to the legislature in 1947 for passage. After final passage or final rejection the commission shall be disbanded.

ITEM II—*The reorganization of the State Board of Health.* There has been a feeling for some years that the State Board of Health should be reorganized and that its membership should be enlarged. Since its inception in 1881 it has consisted of four physicians. With the development of the health ideal, however, there is a great reason for incorporating other groups. We would suggest a seven-man board, to consist of three physicians, one dentist, one sanitary engineer, and two laymen, one of which laymen shall be a woman.

The manner of appointing these members is left to the discretion of the Policy Committee. We would, however, make this recommendation that the members be appointed to serve for a definite term (four years), and that the terms be staggered. The manner of appointing the state health commissioner, who is to be secretary of the State Board of Health, is left to the discretion of the Policy Committee. We are very anxious, for purposes of good administration, that it be clearly understood that the health commissioner is the *executive* officer of the State Board of Health as a branch of government, and that his executive authority stems from the governer to whom he is directly and solely responsible. The board itself should have no executive or administrative function whatever. It is a *legislative* body which shall make rules and regulations for the enforcement of the law, approve appointments of health officers, and determine matters pertaining to general policy. It is our opinion that the statement of the duties, powers, and responsibilities of the State Board of Health and of the state health commissioner should be about as they have been in the past, with perhaps increased emphasis on the idea that the functions of the board are *legislative* while those of the state health commissioner are *executive.* The state health commissioner should *not* be a voting member of the board. While the board is in session the commissioner should serve as the secretary of the State Board of Health, and should keep all records and minutes and should be the servant of the board in its proper functions.

ITEM III—*The means of encouraging the development of full-time health departments in the various cities and counties as soon as possible.* Attention is called to the fact that the law of 1935 permits but does not require counties, groups of counties, or county and city to set up full-time health departments. This is a very important matter inasmuch as most states to the east, south, and the north of us already have developed full-time health departments for nearly all of their counties or cities. It is now generally agreed that the part-time health officer is utterly inadequate to

the proper execution of such an important office covering such a wide variety of activities.

Inasmuch as it will be impossible to get personnel for such health departments in the immediate future, and that it is likely it will be two years or more before the war is over and peace develops to a place that we would have personnel, we strongly recommend that thought be given in the interim to the problem of encouraging the development of these health departments, and that legislation be prepared for the legislative session of 1947, looking toward such development of full-time health departments.

ITEM IV—*Plans for developing a fund for the building of proper health offices for full-time health departments.* Attention is called to the fact that health departments have peculiar physical needs. The buildings which house them should be designed for the purpose; they should be clean; they should be attractive; and they should be the object of community pride. They should be located in such places that the people would like to come to them. They should be separate from the buildings used by the local departments of government inasmuch as such buildings were designed for an entirely different purpose and are commonly not clean nor convenient.

To this end we suggest something of the following nature: Supposing that each county would set up a fund into which they could accept gifts, endowments, subscriptions, subscribed funds, and direct appropriations, or could upon the wish of the people and the decision of the county commissioners set up a small mill tax which fund would accumulate to the point where it would be most equal to one dollar per capita. At the time that it reaches this figure the county should still be permitted to accept gifts of various sorts but not to increase the fund by the addition of tax funds. It has been shown many times that an adequate health building can be built for just about one dollar per capita. It would be understood that if this fund were accumulated and not used after a period of ten or fifteen years, as the committee will decide, such funds would revert either to the general fund or to some other such fund, as the school building fund, if such a plan is practical from a legal standpoint. Means might be taken if it is legal (it is not for us to say about that) to permit the building to be built and partly paid for from such funds, the building later to be amortized by a mill tax or other properly-arranged financial arrangement.

ITEM V—*The need of two new divisions in the State Board of Health.* We respectfully call attention to the fact that there is very great need for certain work that should be done by the State Board of Health which is not being done. Obviously, this will call for additional expense, and we feel that we should like to have the approval of the Policy Committee in asking for such funds in the future.

The first of these divisions to which I refer is that which would have to do with the diseases of middle and advanced age. As a matter of fact, we are all growing old, and we have recently been much concerned over the fact that a great many people are dying of cancer, organic heart disease, and diseases of the blood vessels and the kidneys. These debilitating diseases can hardly be prevented, but they certainly can be delayed in a large percentage of cases. The public needs instruction in the matter of prevention of death from cancer and heart disease. Furthermore, there is great need that studies be made so that we would know just how serious these are among our people. Attention is called to the fact that if we could by such means keep people on their feet and working months and years longer than they otherwise would, they would not only be happier, more comfortable, and enabled to enjoy life much better, but they would thereby be kept off welfare, relief lists, old age benefits, and the like. It seems likely that we could considerably lengthen human life, that we could greatly improve the enjoyment of the latter years of life, and that we could save a great deal of money that would need to be spent for relief if these people become ill. The sums of money needed for this would be very small indeed as compared to the sums spent on the relief of invalids and aged persons. Twenty-five thousand dollars a year would be quite adequate, and indeed much more than we could spend until the war releases personnel.

The second division that we should like to set up, and which we do not now have, is one of dental public health. By all odds, the commonest ailment of humankind is dental caries or cavities in the teeth. Something near 90 per cent of the people have these defects in one form or another, and great sums of money are spent to correct them. Only a few years ago we had a very poor understanding of what causes dental caries. In the past five years, however, tremendous advances have been made, and we are now in the position to say that we really can do something about it. This work would be largely educational; it would involve education of the public in the proper diet and care of the teeth. It would not involve the diagnosis and treatment of the teeth. It would consist of demonstration work, finding cavities so that the school children and others would go to their own dentists, and it would also consist in laboratory work which would help us to understand what is going on in the mouths of persons who have many cavities. Twenty-five thousand dollars would be ample for such work.

ITEM VI—*Improvement in the laws having to do with the quarantine of tuberculosis.* It is understood that an individual with advanced tuberculosis may be extremely dangerous to the healthy population, particularly if children are exposed to his sputum. The patient himself may be rather comfortable, and is most dangerous when *he is too sick to work* and *too well to stay in his bed or in his own room.* In such case he is likely to be up and about, all over the house and about the town,

spreading this disease. At the same time he is both injuring himself and endangering the general public. We believe that a bill should be passed which would make it possible to compel these persons who are believed to be unsafe to enter one of the state tuberculosis sanatoriums, and to stay there until he is fit to be out. Or if there is a county sanatorium which would be in position to take him, he should be sent to such an institution.

The defect in the law at the present time is that according to present statutes we cannot forcefully remove such an individual from his *county* jurisdiction, and therefore he can only be quarantined in a sanatorium if there is a suitable institution in that county, which is not true in most instances. It then becomes necessary to quarantine him locally, which is quite expensive and not nearly as effective. Most counties refuse to accept such an expense.

Attention is called to the fact that the individual himself would be much better off if he were in such an institution rather than running at large. If a patient is unwilling to abide by the recommendation of the health officer, it might be well to set up a commission of three physicians, one of whom is the health officer, to pass upon the fact as to whether or not he is dangerous to the community. Such a commission should use x-ray, laboratory findings, and such other physical data as would establish this point. Some such law as this is strongly urged by the Tuberculosis Association of the State of Indiana, by the Tuberculosis Committee of the State Medical Association, and by the Trudeau Society of Indiana.

ITEM VII—*Inspection service and licensing of hospitals practicing medicine, surgery, and obstetrics.* For several years the State Board of Health has had such an inspection service having to do with maternal and infant health in the various hospitals. We believe this service has been the most important reason why there has been a definite decline in the death rates of mothers and babies in recent years.

We are recommending this same sort of inspection and licensing for all hospitals where physicians treat medical, surgical, and obstetrical cases. This would simply be an extension of the present maternal and child-health service, and should bring considerable improvement in hospital management and care. Some such bill has been written and is being offered under the sponsorship of the Indiana Hospital Association. We shall welcome this additional opportunity for service, *but* the attention of the Policy Committee is called to the fact that in our opinion it would be quite wrong for the State Board of Health to have such inspection over and licensing of various *domiciliary* institutions, such as nursing homes, convalescing homes, boarding homes, foster homes, resting homes, sanitaria, and such other places where well, sick, mentally defective, infant or aged persons may go simply to *live* and be boarded.

If the Board of Health should undertake to inspect and license all these homes it would require a very large staff with large sums of money, and we are very much afraid it would detract our attention from the much more important matter of protecting the citizens of the state from conditions directly related to health. In other words, this would be a diversion from our real duties whereby we protect from disease the entire population, and particularly those who are young and vigorous. We believe that these domiciliary problems properly belong under the Welfare Department, and would like to have turned over to the Welfare Department such supervision over the nursing homes as the Board of Health now has. We will, of course, be glad to offer such technical advice concerning plumbing, sanitation and related subjects as may be needed by the institutions or the Welfare Department. This is important work but belongs to the Welfare Department, in our opinion. We do not feel qualified to make recommendations covering the moral, cultural, and ethical relations involved.

ITEM VIII—*The matter concerning the continuity of the personnel in the Stream Pollution Control Board.* Attention is called to the fact that the Stream Pollution Law is written in such a way that it might very well deprive the board of some very valuable personnel. We recommend that instead of a six-man board it be made a seven-man board, and that the politics of the three ex-officio members, namely, the lieutenant-governor, the secretary of the State Board of Health, and the commissioner of conservation not be considered, and that the remaining four men should be two Democrats and two Republicans. In this way it will be possible to retain the services of both Mr. C. K. Calvert, of Indianapolis, and Professor Wiley, of Purdue University, who are now members of the board and who know more about stream pollution than anyone else on the board. It would be very disastrous to lose continuity and to lose the services of these two men, thereby setting back the work that has been done in that important board. Stream-pollution control is of the utmost importance, and should go on as rapidly as is possible under the present conditions of shortage of labor and vital supplies.

ITEM IX—*The matter concerning postwar building plans.* Attention is called to the fact that there is particular merit in sanitary structures from the standpoint of postwar construction. We refer to extensions to sewer systems, improvement to old sewer systems, sewage treatment plants, water purification plants, extension of water mains, and the like.

The advantage of this type of construction lies in the fact that they will serve the public health; they can be pointed to with pride; they will occupy the time of large numbers of men; they require relatively unrefined building materials, such as gravel, cement, re-enforcing steel and the like, which materials will be more quickly available than

will be the highly-refined materials required for the construction of highly-differentiated office buildings and other public structures. We bespeak the approval of such projects.

If the State Board of Health work is to expand, as seems certain it will, an additional building will be needed when the time comes for such appropriation.

ITEM X—*The need of emergency health legislation.* Attention is called to the fact that a great many of the men serving as health officers are now quite elderly, there being one instance in which a health officer is actually ninety-five years of age. These men are in many instances not able to perform their duties as they and we would wish. As a matter of fact, several of these men have recently died while serving as health officer. There are several instances at the present moment where we are at a loss to know how we shall find other health officers to serve if the present law is enforced, which requires that all health officers must be physicians.

We are suggesting then that in case it is impossible for the local appointing officials to find a physician to serve as health officer, they shall in this emergency be permitted to designate (with the approval of the State Board of Health) some layman as being the custodian of the records and as being the person who will collect death and birth certificates and forward them to the State Board of Health. They should also have the power to issue burial permits upon receipt of a death certificate.

We wish to remind the committee that prior to 1935 there were some two or three hundred laymen serving as health officers in the various towns of the state, and that on such occasion they established quarantine simply by tacking up a sign on a house which had been reported as having a person or persons with infectious disease, and that they removed the sign when the attending physician told them that the premises would be safe. It would seem advisable that we resort to this device for handling this emergency situation, and that this arrangement continue until such time as the governor shall declare the emergency as being no longer existent. Unless something of this sort is done, we shall be unable to collect birth and death records from the various communities, and our vital statistics records will be seriously impaired.

ITEM XI—*Concerning birth and death registration.* Attention is called to the fact that a bill is being prepared by Mr. Wright, of the Indiana State Board of Health, which document is essentially the uniform bill approved by most of the states concerning the important matter of birth and death registration. If this bill should pass it will bring our law and procedure into harmony of that of most other states of the union, and thereby make it much easier for our citizens to get birth and death records and have them as reliable as possible. Furthermore, if we have a uniform law with other states it will make our vital statistics more accurately comparable to other states, so that we may compare ourselves in these vital matters with the rest of the nation.

In recent years there has been a tendency toward legislation which would take the birth and death records away from the health officer and put them in the office of the county clerk. We think that this is a step in the wrong direction. If we are considering the further development of the health ideal, then we should be trying to *improve* the efficiency of the health office and should do so by keeping health records in the health office. A complaint has been made that sometimes these records have not been accessible there. If, however, the health office were further developed, as is being contemplated, they would become *more* accessible. Attention is also called to the fact that the records will not be accessible out-of-hours, even in the clerk's office, and that on holidays, Saturday afternoons, and Sundays in all probability the health officer's records would be much more available than if they were in the clerk's office. Furthermore, we believe that the records should be regarded as confidential, and that in the hands of the health officer they will be more likely to be so regarded.

Attention is further called to the fact that very frequently scientific and technical health terms are used on these records which would not be understood by the personnel at the clerk's office. Furthermore, it is often necessary for such records to be sent back to the physician in charge for more accurate wording, and this could hardly be done if they were in the clerk's office because he would not be in a position to know whether the terms used on a certificate were accurate.

We should like for the committee to very carefully consider our point that these are *health* records, and they can be of most use in the *health* office.

Inasmuch as a law transferring such records to the county clerk's office was passed at the last session, but the same law had a defective title, we believe that this matter should be clarified by repealing the act with a defective title if such is necessary.

ITEM XII—*Concerning the matter of salaries for personnel.* Attention is called to the fact that our salaries are lower than for most other states. This means that in the crisis through which we are now passing we are in some danger of losing our personnel, and in such case, if we should have a disaster such as a flood or tornado, we might be very seriously handicapped. Furthermore, unless we can pay salaries that correspond to those of other states we shall not be able to recruit well-qualified personnel as they come back from the service.

It is not so much that we are trying to get higher salaries for our people, although certainly we might be permitted to wish to do that, but unless we can pay salaries which are comparable to

those of other states we will lose our health personnel and disrupt our health organization. Attention is called to the serious plight in which we find ourselves with regard to part-time health officials. Many of these men are extremely busy practitioners who are paid sometimes as little as twenty dollars or twenty-five dollars a month, yet they have jurisdiction over an entire county. They sometimes feel that they are not obligated to give as good services as they would if their services were more highly valued. In order to help correct this situation, we are suggesting that either the health officers be paid a higher per capita salary or that they be permitted to charge not more than one dollar for copies of birth and death records which they are asked to supply. This latter method would have the effect of increasing their very inadequate salaries, and yet the expenditure would not show on the tax rolls inasmuch as the persons who get the service would be the ones who pay for it. This method of increasing the income of health officers is the one that is preferred by the Indiana Association of Health Officers, as voted in a meeting which they recently held.

ITEM XIII—*The development of an Advisory Health Council.* There are many occasions in which the State Board of Health and the state health commissioner would like to have advice from the people of the state; would like to know what their feelings may be about a given matter; and would like to have a ready means of approaching the various organizations of the state which play such an important part in the government of our state community.

We think it would be well if such an advisory council were set up which would invite, on proper occasions—perhaps two to four times a year—representatives from the various official and nonofficial organizations of the state. By this we mean that there would be representatives of the governor's office, universities, the labor bureau, and other such government agencies who would come and meet with representatives from such organizations as the State Tuberculosis Association, the Parent-Teacher's Association, Women's Clubs, Red Cross, Service Clubs, and the like. Such an advisory council would have no powers whatever except to advise. It would have no legislative powers, no executive powers, and would serve entirely without compensation or without expenses being paid from state funds.

These meetings could be called at intervals to meet at the State Board of Health Building, or wherever there is an adequate auditorium for such purpose, either in Indianapolis or some other part of the state, if there was a particular problem that was of local interest. Smaller advisory health councils might properly be organized in other counties or health districts.

We believe that this would be a very valuable arrangement because it would instruct many people in matters pertaining to health, and would permit the board of health and the health commissioner to catch as early as possible the feeling of the public in regard to the various health matters, and then in turn to direct their interest in proper channels back to the people.

ITEM XIV—*The development of a strong Department of Public Health at the Indiana University School of Medicine.* Indiana University is eager to develop a strong department of public health in the medical school, which would act in conjunction with the Indiana State Board of Health in giving short courses in matters pertaining to health to various groups in need of such instruction. For example, there could be short courses in public health practice given to physicians, in dental public health given to dentists, and short courses in public health for nurses and others who needed to develop their technical understanding of the matter. Likewise, courses could be given to lay groups, such as operators of restaurants, swimming pools, water purification plants, sewage treatment plants, school janitors, school principals and other such groups as are in need of increased understanding of important sanitary measures.

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## ABSTRACT

### POSTWAR CONTROL OF VENEREAL DISEASES

The postwar period will present far greater assets for the control of the venereal diseases than have been available at any previous time, Lieutenant Colonel Thomas H. Sternberg and Captain Granville W. Larimore, Medical Corps, Army of the United States, predict in *The Journal of the American Medical Association* for January 27.

"A tremendous number of physicians and lay personnel trained and experienced by the Army in the principles of venereal disease control," they say, "will be available. The dilution of the postwar population by nine million soldiers will raise the general venereal disease educational level to a new high, and it seems certain that future venereal disease control programs will be accorded increased public support. In this connection, efforts to reimpose a blackout on the venereal diseases are doomed to failure. The remarkable advances in treatment climaxed by the introduction of penicillin will add great impetus toward achieving the goal of universal case-finding and case-holding. Mass wartime experiences will add considerably to the venereal disease control armamentarium.

"These factors, added to the stabilization of community life and the return of opportunity to follow the natural instincts of monogamous relationships, all lead to the conclusion that we shall be presented with an unprecedented opportunity to reduce the incidence of the venereal disases to a manageable minimum."

# Military News

Captain Alfred J. Dainko, of Whiting, has been transferred from Douglas, Georgia, to Craig Field, Selma, Alabama.

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Dr. Donald Grillo, of South Bend, has been promoted to major. Major Grillo is still stationed somewhere in China.

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Captain E. G. Neidballa, of Bristol, is still in India. He is doing surgery and x-ray work in an evacuation hospital near Calcutta.

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Word has reached us that Dr. Horace M. Banks, of Indianapolis, who is serving with a general hospital at a New York APO address, is now a lieutenant Colonel. Congratulations, Colonel Banks!

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Lieutenant Commander M. E. Gross, of Ladoga, has been transferred from the University of Kansas, where he was associated with a V-12 Unit, to the Naval Air Base, at Bunker Hill.

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Promotion to a captaincy has been reported for William B. Ferguson, of Indianapolis, who is now somewhere in China. Captain Ferguson was in India until last November, when he spent about two weeks in Burma, then was sent to China.

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Commander Justus M. Fleming, of Elkhart, is at a Naval operating base in southern England. He has been overseas since November, 1943. Commander Fleming likes the country, and states that he is well.

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Major Arthur W. Kistner, of Elkhart, is not far from the German lines in France. He says Paris is the most beautiful city he has ever seen. The people are all appreciative, and proved it by cheering and waving as they drove by.

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Lieutenant Colonel James E. Jobes, of Indianapolis, who is serving in the Army Medical Corps, has been awarded the Bronze Star Medal for his services as surgeon in the European Theatre of operations. Major General Paul R. Hawley, of College Corner, chief surgeon of the European Theatre of Operations, made the presentation.

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In a V-Mail letter, Major Robert D. Fry, of Indianapolis, tells us that he has been doing some traveling in the past two months, having gone from Camp Barkeley, Texas, to France. He writes: "I am now chief of surgery with a general hospital, somewhere in France. If you know where the mud is the deepest, that is where we are."

Dr. Robert M. Lohman, of Fort Wayne, is serving with the Army Medical Corps, at Camp Gruber, Oklahoma.

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Lieutenant P. T. Lamey, of Anderson, who has been aboard a ship for twenty-eight months, reported that it would be a pleasure to be ashore again, and that he was to be stationed at the United States Naval Hospital, at Corvallis, Oregon, as of February first.

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A change in rank, from first lieutenant to captain, has been given to Jerome E. Holman, Jr., of Indianapolis, who is somewhere in Holland with the United States Army. We would like to tell more about Captain Holman's address, but censorship regulations forbid publication of information which might be of aid to enemy countries.

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Major Ivan W. Scott, of Indianapolis, who has been at Miami Beach, awaiting reassignment following his return from India, is now stationed at the Walter Reed General Hospital, at the Army Medical Center in Washington, D.C. Major Scott says that he is permanently assigned there to duty in the Out-Patient Clinic.

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"You can find Indiana doctors just about anywhere," writes Captain George K. Hammersly, who is with a general hospital in the Normandy area. He says, "We have a grand group of men and I am proud to be one of the unit. We know how fortunate we are to be back a ways and not living under conditions that are 'right up there.' As for Normandy in general, one can say, 'Indiana was never like this.' We are all looking forward to 'the day when.' "

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A sergeant paratrooper, John C. Landreth, of Mount Vernon, is reported as having found proof that "some features of home are not so far from the battlefront, after all." Wounded recently in Italy, Sergeant Landreth was treated by Captain Frank W. Oliphant, who had been his private physician at Mount Vernon, and who had previously set a fractured leg which was again fractured among other injuries sustained at this time. He said, "Dr. Oliphant seems to be my private physician regardless of the spot on the globe in which I happen to be." This reminds us of the ballad, "Oh, East is East, and West is West, and never the twain shall meet, Till Earth and Sky stand presently at God's great Judgment Seat. But there is neither East nor West, Border, nor Breed, nor Birth, When two strong men stand face to face, though they come from the ends of the earth!"

Captain Benjamin V. Klain, of Indianapolis, is with a general hospital located somewhere in France. He went overseas from Camp Barkeley, Texas.

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Major Harold C. Adkins, of Indianapolis, writes in a recent letter: "Just received the October number of THE JOURNAL, and appreciated it very much. I saw several of the gang from the Indiana General Hospital a few months back. Also visited Major Horace Banks last summer. One of my squadron surgeons is from Peru. I saw Kenneth Thornburg in North Africa, and Roy Hynes in Italy. It is good to see and talk to someone from the old home town. Regards to all."

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Major Milo O. Lundt, of Elkhart, on duty with the North Atlantic Wing of the Air Transport Command, recently flew to Paris, in charge of the first experimental flight in the transporting of whole blood. They spent the three following days in Paris, and found the people happy and well-dressed. Major Lundt thinks that Paris is the same as always, except that there is a scarcity of food and heat. Captain Lundt has lately made a trip to Goose Bay, Labrador, on a similar mission.

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A somewhat different letter about New Guinea has come to our attention. It is from none other than our own Major George R. Dillinger, of French Lick, who writes: "To date all the stories I have heard about New Guinea have been exaggerated. I'm sleeping under blankets every night, and the various tropical diseases are under control. I'm not at a permanent station as yet, but will write again when I do have a more permanent address. I hope, but rather doubt, that I will be back for the state and A.M.A. meetings next year. In the meantime, any information you can send will be very much appreciated."

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In a letter to his brother, Captain Floyd S. Martin, of Goshen, said: "My experiences in France, Belgium, and Germany can hardly be highlighted on V-mail. I think I remember reading that Hoover kissed the babies in Belgium—well, he didn't kiss any more than I did in the same amount of time that it took to liberate a swath through that wonderful country. The people went wild.

"I rode the first vehicle with a red cross, not far behind the front of our column, and for thrills it was the choicest spot to be in. Church bells were ringing and the people in the cellars would come out, running to welcome the Americans.

"Well, I tagged all our boys and a lot of the artillery, engineers and infantry wounded—all told, more than the total number I was really supposed to take care of.

"The war, seeing it from here, isn't nearly over yet—but I have hopes of seeing it through right here in these front lines."

Captain Karl W. Vetter, of Elkhart, has been traveling some lately, and is now in Italy. He has spent a rest period in Cairo, which is a beautiful city, and has also made a trip via camel to the edge of the desert where Churchill and Roosevelt had their famous conference. Captain Vetter has also been in Rome recently, where he received the Presidential Citation for his unit.

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Major Irving Mishkin, of Elkhart, is in charge of the electrocardiography service on a transport. He has been in Italy, France, Corsica, and North Africa, and speaks of the tragedy of homeless, wandering European children—the aftermath of war.

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Writing from a Minneapolis A.P.O. address, Captain George W. Macy, of Columbus, says: "I am writing this to report my change of address. I was formerly at Buckley Field, Colorado. As far as I know, there is no secret about the location of this address. I am now on Southampton Island. The island is in the very northern part of Hudson Bay. It is just below the Arctic Circle. Life here is fairly 'rugged,' but we do have comfortable, well-heated buildings—some of them with plumbing! The food is excellent. The morale of the men here is surprisingly high."

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Word has been received that Captain William N. Jones, of Anderson, who was with the Johns Hopkins Hospital Unit in Australia, has been moved to the Philippines, their new location being within twelve miles of the air field where Major Eugene W. Austin, also of Anderson, is now located. Both doctors have been located in the South Pacific area for more than two years. This is the first place Major Austin has been stationed where the natives wear civilized clothing, and where most of them speak English. He reports that living in or near a civilized community where there are stores is a real experience after two years in the jungles.

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Captain Henry M. Pickard, of Elkhart, has written us, giving his correct address. He is with a clearing company, and he further writes: "We are not having a good time over here, contrary to public opinion. There is heat, dust, dirt—more heat and dust. We are getting tired of the war—want it over, and as quickly as possible, but all of us feel that we want to stay until it is all over. Those of us here in Italy feel that we are lucky to be here because it is the best theatre of operations. Many of us have been over here from the start, and wear four campaign stars on our overseas ribbon. So far, only four have been given out—one for the original landings in North Africa, one for Tunisia, one for Sicily, and one for Italy. In our battalion there are four Hoosiers who sport four stars—Ted Lorenty from Gary, Jack Kemp from Michigan City, Ray Nelson from South Bend, and myself." Congratulations!

According to news from Captain Harry L. Sandoz, of South Bend, "long undies," mackinaws, and boots are the winter garb for a unit set up in tents somewhere in France. He has received a rather unusual payment for medical care given to a French child—the child's father gave him five partridges for a special dinner.

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After spending six weeks in a general hospital in India, Major Wendell L. Spalding, of Mishawaka, was given a fifteen-day sick leave which he spent seeing the sights of India. He did his Christmas shopping in Calcutta until the weather became too warm for comfort, then he took a train for a mountain resort—*the* resort of India—where he enjoyed both the temperature and the beautiful scenery. According to Major Spalding, "only millionaires and soldiers could afford this resort."

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That colonels in the Army have a heart is manifested by one who took a little time to make someone happy at home. We refer to a letter received by the mother of Major Fred Reynolds, of Indianapolis, who is chief of the orthopedic service in a general hospital in England, and whose commanding officer, Colonel Marcellus A. Johnson, Jr., wrote as follows:

"If I guess right, your son has probably never written you about the tremendous contribution he has made to the restoration of the battle casualties to normalcy. May I, who feels grateful for such officers as he, tell you at this Christmas time, it is such men as Major Reynolds, who through long hours of service have contributed such wonderful work, that this post rates *superior* and second to none.

"Many a mother will have her son return because of him. Many a man will walk again because of his skill and work. I am proud that he is a member of my command. He is a gentleman and a swell soldier, always dependable, and always untiring in his work. His patients idolize him and have great faith in his skill.

"I know his absence has dimmed the holiday season, but I am sure the knowledge that your son is of such great service to mankind will compensate somewhat for your loneliness."

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On duty as a battalion surgeon with a division of the First Army, Captain Elmer G. Koehler, of Elkhart, was among the first troops to enter the city of Cherbourg, where he was put in charge of evacuating German patients and staff from the Louis Pasteur Hospital. After Cherbourg came the battle toward Paris. For many weeks they lived in foxholes, the Medical Corps having established First Aid stations within six hundred feet of the fighting. Also among the very first to enter Paris, the extravagance of joy and gratitude displayed by the citizens of Paris toward the American liberators was an experience to be remembered always. The division stayed three days in Paris, proceeding through Belgium, and finally into Germany. We have learned that in the crossing of the Siegfried Line, Dr. Koehler received a hip injury, later complicated by osteomyelitis and pneumonia. He was evacuated to England for hospitalization.

Captain Phillip E. Yunker, of Evansville, who is stationed with a general hospital somewhere in the Southwest Pacific, has reported that he is enjoying his work and finds it interesting; says he is getting a lot of orthopedics—never liked it but the Army has made him like it. The physical plant is one of the best, said by some to be the best in the S.W.P. It was one of the first over there.

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A most descriptive letter has been received from Captain C. V. Rozelle, of Anderson, who is with an air service squadron. We take pleasure in printing it herewith:

Somewhere up in Italia.

"Long time and no letter, and also no JOURNAL, which I miss very much. So I thought I'd drop you a few lines and give the latest address and so forth. As you will note, I have quit twisting tails off lions and riding camels to and from the oasis each day, and defending myself against roving bands of Arabs at night. We came up here to make Kraut where the sun shines. Arrived in our present location just three weeks after the Krauts had been chased out, and found the place well planted with mines and booby traps. The roads in most places had been cleared only four to six feet, and those not believing in signs learned the hard way. Roadside crosses and wrecked tanks, trucks and vehicles told the story of the fury in these parts. I recently saw one stretch of road north of Rome which averaged a wrecked tank, gun, or vehicle every hundred yards for more than fifty miles.

"Your papers and magazines told the story of the Southern France invasion, but its preparation and accomplishment were part of our job, and words fail to describe the thrill of the whole thing. It was so perfectly timed, planned, and carried out that it would have made the slickest Hoosier basketball play look sick. There was actually little secrecy about the whole affair. In fact, a few days before D-Day, Propaganda Sally, the Nazi radio broadcaster, told us that they knew exactly how, when, and where we were coming; would be glad to see us, and would have a warm welcome awaiting us. True, they worked up till the last day placing barricades and barbed wire in landing fields, but our gliders and paratroopers went into spaces they thought impossible for us to get into, and the complete and flawless success of the whole thing attests its perfection. Imagine huge numbers of transports tearing down the runway in darkness and dust so thick you couldn't see their wing lights one hundred feet away, and one taking off every sixteen seconds; giant bombers flying for hours and having just two minutes and five seconds to be over the target, drop their bombs and get out before other fire would blow them out of the skies, and you may get some idea of how this thing clicked.

"That Hoosier doctors are well represented over here is proved by the fact that I met Major Adkins, of Indianapolis, and Captain Berkebile, of Peru, in the troop carrier group which we serviced in the above operation; Major Daugherty, of Terre Haute, at a station hospital to which we evacuated; and Captain Russell, of Frankton, who is with the group of fighter-bombers we are now servicing. I ran into Major Palm in Rome, the first time I'd seen him since he sang the blues to us in the Claypool at the '41 convention. Had a note from Major Benny Kraft, who is with a general hospital in these parts, but some distance south of us.

"Personally, I am fine, a bit thinner but still very sound. Am up an alley waiting for the parade to pass, and then go home if they don't want me to also stay for the 'after show.' Time marches on, and he also serves who only stands and waits. My best to you and all my friends there for the coming year."

According to word received, Major H. H. Oyer, of Fort Wayne, is now in Caracus, Venezuela, South America.

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Captain F. Paul LaFata, of Gary, has gone overseas from Randolph Field, Texas, with a medical air evacuation squadron.

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A letter from Captain Theodore D. Arlook, of Elkhart, written to the Elkhart County Medical Society *Service Bulletin* is reprinted herewith: "I don't know when I'll be getting home. There are still several of us old-timers left in this organization, and we will all be eligible to come home, but they are not yet ready to send us back as we are still badly needed. I am anxious to get back, but I'm certainly not losing anything we need except good American food and recreation."

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The Bronze Star Medal for "meritorious service in connection with military operations against an enemy of the United States, in France, from July 15 to September 17, 1944," has been awarded to Captain John R. Matthew, of Knox. A censored report from headquarters in France stated that this was the period when his infantry was engaged constantly with the enemy, and that Captain Matthew worked constantly, skillfully ministering to injured soldiers and enabling many men to return to further service. Thus has another Indiana member scored for Uncle Sam.

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Some interesting notes gleaned from a letter sent by Lieutenant Commander Keith E. Selby, of South Bend, to Major Harold Dale Pyle, of South Bend, have reached us through the St. Joseph County Medical Society *Service Bulletin.* Commander Selby wrote, "The menace of Jap snipers is still a source of great dissatisfaction to me." Another "dissatisfaction" seems to lie in the fact that he has to rely on the rains for showers and, as the rain stops very quickly, it requires fast work to avoid being caught soaped when the sun comes out.

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Captain Julius C. Travis, Jr., of Indianapolis, was one of the first men who landed under fire in the Philippines with the first echelon of the Air Force headquarters. According to reports, the group was pinned down for more than a week by Jap bombing and strafing. Soon after they dug in, a raging tropical typhoon struck the area, bringing torrents of rain. A cocoanut tree fell on a tent, crushing the chest and throat of an enlisted man. Working by candlelight at 3:00 A.M., Captain Travis performed a tracheotomy, utilizing a piece of rubber tubing taken from a Navy pneumatic life belt. This is only one of many such incidents that could be told concerning the miraculous services performed by our physicians in the armed forces.

In a letter sent to one of his colleagues, Captain Harry S. Rabb, of Indianapolis, told of living in a house on a large French, ex-German camp, and that it was a welcome relief from tents, but that he did not know how long they would remain there.

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On duty with the United States Navy, Lieutenant J. C. Ambrose, of Noblesville, has been on sea duty for seven months. Formerly, he was senior medical officer at the Dearborn Medical Base, Dearborn, Michigan.

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After spending a three-week leave at Elkhart, Major Richard B. Stout has been assigned to the orthopedic division of the Wakeman General Hospital, at Camp Atterbury, Indiana. It is of interest that this hospital, in its sixth month of active operation, is the largest medical installation of its kind in the country. Major Stout served as chief of the surgical division of a station hospital in the North Pacific for eighteen months before he returned to this country.

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We take the privilege of quoting a letter received by "MedSoc" from Colonel Morris C. Thomas, of Oaklandon, as of January first:

"From the date would appear that I had made some New Year's resolutions and was trying to keep them. Such is not the case, so far as resolutions are concerned. Have been receiving your letters quite regularly; THE JOURNAL not so regularly. The first page of THE JOURNAL to be perused is that of Military News—to see who is where, and what they may be doing; also, to see who may have given up trying, and have come into the fold.

"After reading some of the letters in THE JOURNAL, life in a general hospital in England seems like a picnic in comparison, not the Uhlen Club variety, however. We have what we claim is the best setup here, and have had few to dispute the word. Have special staff for treatment of eye, and of thoracic injuries. The latter is my pet, albeit have very little time to spend on it. The gang on the other side keeps rolling them to us, so that we never lack for work. They have no chance to follow up their work, but will say for them that their cases get back to us in excellent condition, both surgically and physically. Considering everything, if anyone deserves praise, it is the medics in the forward installations.

"There are a few Indianapolis medics in this vicinity, but haven't seen very many of them. Major Megenhardt is a regular attendant at our camp medical meetings. A recent new arrival from the states actually brought clothes in his foot locker. A friend told him the stuff was plentiful over here. No need to worry, the "friend" was a teetotaler—fair warning!

"Best wishes for the New Year to all of the Medics," and that goes for you, too, Colonel Thomas.

# News Notes

Dr. E. K. Black, of Wabash, has been named as city health officer, filling a vacancy created by the resignation of Dr. L. E. Jewett, of Wabash.

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On December twenty-fifth, Dr. and Mrs. Albert C. Yoder, of Goshen, celebrated their fiftieth wedding anniversary. An open house was held.

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Members of the Business and Professional Women's Club honored Dr. Kathryn Bryan, who is a physician at the Logansport State Hospital, with a dinner. Dr. Bryan is retiring and leaving the city.

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The Indiana Student Health Association recently elected new officers, naming Dr. Louis F. Ross, medical director of Earlham College, at Richmond, as its president. Other officers include Drs. George F. Parker, of Greencastle, and S. J. Miller, of Lafayette, as executive committeemen.

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The reappointment of Dr. William M. Dugan, of Indianapolis, as a member of the Board of Managers of the Marion County Tuberculosis Hospital, at Sunnyside, has been announced recently. He has been a member of the board for the last two years.

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Dr. Henry G. Coleman, of Odon, who has been a lieutenant in the Army for several years, has been placed on inactive status due to physical disability. He has spent the past seven months at the Fitzsimmons General Hospital, at Denver, Colorado. He has returned to his home to recuperate.

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Dr. James F. Balch, of Indianapolis, has returned from overseas, having been released from active duty, and has resumed his private practice. Doctor Balch served as a major in a general hospital in England, being overseas one and one-half years. He is mighty glad to be back home, and we are, indeed, pleased to have him back with us.

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The medallion representing a fellowship in the International College of Surgeons has been awarded to Dr. Thomas B. Noble, of Indianapolis. The award was presented to Dr. Noble by his son, Dr. Thomas B. Noble, Jr., of Indianapolis, at a recent dinner meeting. The award cited Dr. Noble's long and faithful service as a pioneer surgeon in Indiana, and a recognition of his work in the advancement of the surgical profession.

## MEETINGS CANCELLED

The midwinter group of meetings that was to be held at Chicago starting February tenth, has been cancelled in compliance with the request received from the Office of Defense Transportation. These meetings included the nineteenth annual National Conference on Medical Service; the Council on Industrial Health; and the Congress of Medical Education and Licensure.

The annual meeting of the American Medical Association that was to be held at Philadelphia, in June, has also been cancelled.

Other cancellations are the Annual Clinical Conference of the Chicago Medical Society, and the Midwest Conference on Rehabilitation, by the Institute of Medicine of Chicago. The American College of Surgeons has also deferred its 1945 War Sessions, four of which were to have been held in February.

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## SPRING REFRESHER COURSE IN OTOLARYNGOLOGY

The fifth semi-annual refresher course in laryngology, rhinology, and otology will be conducted by the University of Illinois College of Medicine, at the College, in Chicago, March 26 to 31, inclusive, 1945. While the course will be largely didactic, some clinical instruction will be included. This course is intended primarily for ear, nose and throat specialists. As the registration is limited to thirty, applications will be considered in the order in which they are received. The fee is fifty dollars. When writing for application, please give details concerning school and year of graduation, and past training and experience. Write to Dr. A. R. Hollender, 1853 West Polk Street, Chicago 12, Illinois.

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RADIO CALENDAR—FEBRUARY, 1945

"Your Health in Wartime"—with Doctor Goodhealth — WFBM, Indianapolis—every Monday at 3:30 p.m.

February 5—"Social Hygiene Day"
February 12—"Health in Lincoln's Time"
February 19—"The Pigeon Problem"
February 26—"Nursing—A Career and a Duty"

Other broadcasts: Vigo County Medical Society, WBOW, Terre Haute, Thursdays at 12:15; St. Joseph County Medical Society, WSBT, South Bend, Fridays at 1:45.

Dr. R. B. Engle, who has been practicing medicine at Farmland for nearly twenty-five years, has moved his office to Winchester where he will continue to practice.

## INDIANA UNIVERSITY NEWS NOTES

Dean W. D. Gatch, of the Indiana University School of Medicine, has announced the receipt of a gift of five hundred dollars from Mr. and Mrs. A. L. Taggart, of Indianapolis, to the Women's Field Army for the Control of Cancer for use in promoting the control and cure of cancer.

The Women's Field Army is supporting a fellowship in pathology, now held by Dr. Theodore Makovsky at the University Medical Center, and also is paying the salary of a secretary to keep the records of the tumor clinics at the Medical Center and the Indianapolis City Hospital.

At the recent commencement of Indiana University, 110 students were awarded the doctor of medicine degree, as follows:

Raymond A. Abraham, Evansville; Bernard S. Abrams, Cleveland Heights, Ohio; Frank B. Adney, Lebanon; Robert T. Allen, Richmond; Justin E. Arata, Mishawaka; Forrest J. Babb, Jr., Bedford; John W. Beeler, Indianapolis; Roger P. Bissonnette, Wolcott; Joseph M. Black, Seymour; Melvin A. Block, Evansville; James L. Borders, Indianapolis; Irving A. Breckler, Fort Wayne; William L. Bridges, Knightstown; George D. Buckner, Fort Wayne; Thomas D. Carpenter, Columbus; Robert G. Claeys, Mishawaka; William G. Clevinger, Brookston; Joseph E. Coleman, Indianapolis; Hadley L. Conn, Danville; James R. Cook, Hammond; Howard T. Craven, Auburn; Ray O. Creager, Fort Wayne; Paul M. Dassel, Evansville; Richard C. Datzman, Otterbein; Edward T. Edwards, Jr., Bloomington; Harry D. Ellis, Indianapolis; Charles Fisch, Indianapolis; Arthur H. Girod, Decatur; Carl W. Goebel, Fort Wayne; John P. Graf, Indianapolis; Carl L. Green, Vincennes; Frederich C. Green, Fort Wayne; Morris Green, Indianapolis; Richard S. Griffith, Greenfield; Francis G. Henderson, Elwood; Alvin L. Henry, Seymour; Howard J. Henry, Knox; Stanley H. Hoffman, Terre Haute; Frank D. Hogle, Plymouth; Walter H. Hollis, Princeton; Jack H. Horton, Marion; Rex L. Huff, South Bend; George S. Hughes, Indianapolis; James F. Johnson, Indianapolis; Richard M. Johnston, Fort Wayne; Clifford H. Jope, Jr., Indianapolis; Omar A. Kenyson, Jr., Fort Wayne; Charles Y. Knowles, Indianapolis; William A. Koontz, Roanoke; John E. Krueger, Michigan City; Richard N. Land, Richmond; Alexander T. Lebamoff, Fort Wayne; Robert J. Lehman, Berne; Raleigh E. Lingeman, Indianapolis; James G. Lorman, Connersville; John E. Lynch, Lafayette; William E. McDaniel, Indianapolis; Wilbert McIntosh, Terre Haute; Gordon C. McLaughlin, Jr., Terre Haute; John E. Mackey, Evansville; Frank H. Miller, Rushville; Floyd W. Mohler, Markle; Guy Morford, Bicknell; John R. Moriarty, Indianapolis; Mortimer H. Moseley, Pellville, Kentucky; Robert E. Moses, Worthington; Harlan B. Moss, Centerpoint; Ernest C. Murray, West Lafayette; William R. Noe, Seymour; Robert W. Osborne, Windfall; Harry B. Overesch, Lafayette, Paul E. Parker, Jr., Marion; Joseph L. Pedicini, Newark, New Jersey; John F. Phillips, Butlerville; Robert D. Pickett, Sheridan; Robert M. Raber, Indianapolis; Edgar A. Rado, Indianapolis; William L. Ridgway, Evansville; Willard A. Scantland, Richmond; Daniel J. Schlesinger, Hammond; John S. Scott, Richmond; Don A. Sears, Odon; Richard H. Shafer, Alexandria; Harold W. Shonk, Rochester; Walton W. Shreeve, Muncie; Richard A. Silver, Knightstown; Ralph C. Singer, Indianapolis; Charles G. Smith, Indianapolis; Leo M. Smith, Portland; Beaufort A. Spencer, Muncie; Homer R. Swihart, Elkhart; Edward J. Szaulewicz, South Bend; Pierre C. Talbert, Auburn; Donald L. Trinosky, La Crosse; Robert W. Turgi, New Castle; John R. Van Kirk, Kentland; Walter J. Van Sickle, Indianapolis; Richard L. Veach, Bainbridge; John S. Visher, Evansville; Adolph Walker, Mishawaka; Lewis H. Walker, Indianapolis; Norbert M. Welch, Indianapolis; William M. Wiley, Shelbyville; Gerald M. Wohlfeld, Indianapolis; Irvin L. Zeiger, Mishawaka; Stanley Zelman, Indianapolis; Geraldine M. Zix, Indianapolis; Gaylord W. Statler, Fort Wayne; Robert L. Stewart, Sullivan, and Francis E. Stout, Muncie.

## ABSTRACT

### MORE EVIDENCE OF PENICILLIN'S VALUE FOR SUBACUTE BACTERIAL ENDOCARDITIS

Additional evidence that penicillin is of value in the treatment of subacute bacterial endocarditis, a condition which is almost invariably fatal, is reported in *The Journal of the American Medical Association* for January 20, by Martin Henry Dawson, M.D., and Thomas H. Hunter, M.D., New York.

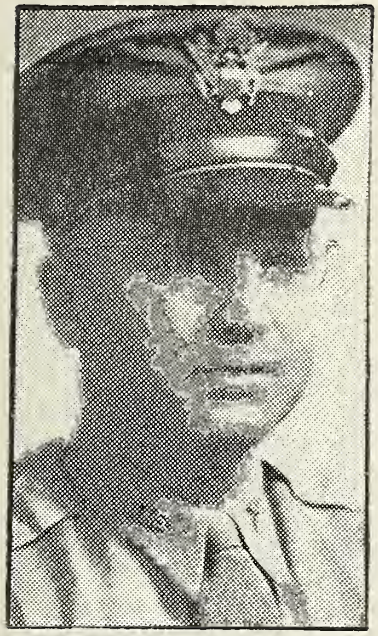
The report concerns the results obtained in the treatment of twenty patients, with a supplemental report on seven additional patients. Although heparin, an anticoagulant, was used in combination with the penicillin in a majority of the patients, the two investigators obtained some encouraging results without it.

The infecting organism was a streptococcus in all instances. "While it is recognized that a long follow-up will be necessary before the ultimate outcome is established," they say, "therapy was apparently successful in fifteen of the twenty patients. All fifteen patients are now clinically and bacteriologically free from infection. In two of the remaining five patients the infection was controlled as long as penicillin was administered, but a relapse occurred when therapy was discontinued. These two patients are still in excellent general health, and it is hoped that it will yet be possible to arrange for a therapeutic regimen which will produce a satisfactory outcome. The remaining three patients succumbed. In each instance death was apparently due to a cerebral embolus. In two of the fatal cases the infection was still present at the time of death, and in the third the situation was in doubt. Further experience is necessary before an opinion can be expressed regarding the value of heparin as an adjuvant to penicillin in the treatment of this disease."

In an addendum Drs. Dawson and Hunter say that since the preparation of their report seven additional patients with this disease have been treated with penicillin. In the last five of these the drug was administered by the continuous drip method into a muscle, and heparin was not used.

"The results indicate that the response was as favorable in this group as in those patients in whom heparin was used," they say. "In six patients the infection has apparently been terminated. The seventh patient relapsed after one course and is now receiving additional therapy. . . ."

# Deaths



*Major Michael A. Rafferty*

## DIED IN MILITARY SERVICE

**Major Michael A. Rafferty**, of Elkhart, was killed in action in Belgium, on November 24, 1944, while serving in the Medical Corps of the United States Army. He was forty-one years of age.

He graduated from the Rush Medical College in 1937, and served on the staff of the West Virginia University from 1929 to 1941, being associate professor in biochemistry at the time of his resignation in 1941, when he located at Elkhart, Indiana. He limited his practice to industrial medicine.

Major Rafferty entered service in June, 1942, being commissioned a captain in the Army Medical Corps, and was assigned to the Billings General Hospital, at Fort Benjamin Harrison. In October, 1942, he began a twelve-week course at the University of Michigan, and in the spring of 1943 he was assigned to the station hospital at Fort Custer. Later he was transferred to Fort Dix, New Jersey, where he was assigned to a general hospital. On November 1, 1943, he was commissioned a major. He was sent to England in March, 1944, and entered France last September.

Major Rafferty was a member of the Elkhart Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**Claude B. Paynter, M.D.**, of Salem, died suddenly on Monday, January eighth, after suffering a heart attack while on duty in his office. He was sixty-nine years of age. Dr. Paynter graduated from the Louisville Medical College in 1906 and located immediately in Campbellsburg, where he was located until 1914, when he established a practice at Salem, where he continued until the time of his death.

*Claude B. Payater, M.D.*

Doctor Paynter had been very active in medical organizations, county as well as state, and had also served in numerous other capacities. During World War I he served as a lieutenant in the 70th Field Artillery, and later became an enthusiastic member of the American Legion, of which he was a past Ninth District commander. He organized the Washington County chapter of the American Red Cross in 1917, and served as its president until entering the World War in 1918. He was county coroner four years, was a member of the Pension Board four years, and at the time of his death was acting surgeon for the Monon Railway Company.

He served as secretary of the Washington County Medical Society from 1913 to 1916; from 1918 to 1920, inclusive; from 1929 to 1939, inclusive, and from 1943 until his death. In 1934 and 1935 he served on the Committee on the Secretaries' Conference of the Indiana State Medical Association; in 1942 and 1943 on the Medical Relief Committee; and as a delegate to the Indiana State Medical Association from 1934 inclusive of 1944.

Doctor Paynter was a member of the Washington County Medical Society, which he organized in 1912, of which he was a past president. He was also a member of the Indiana State Medical Association, and the American Medical Association.

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**Walter A. Hall, M.D.**, of New Albany, died December ninth, at the age of sixty-four. He was a graduate of the Hospital College of Medicine, Louisville, in 1880. Doctor Hall was a member of the Floyd County Medical Society, the Indiana State Medical Association, and the American Medical Association.

**Clarence Earl Barcus, M.D.**, of Indianapolis, died December twentieth at the age of sixty-four. He graduated from the Medical College of Indiana, Indianapolis, in 1903.

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**Edward Moses Corbin, M.D.**, of Sullivan, died December twelfth. He was seventy-six years of age, and had retired from practice a few months ago. Doctor Corbin was a graduate of the Marion-Sims College of Medicine, St. Louis, in 1899. He was a member of the Sullivan County Medical Society, the Indiana State Medical Association, and the American Medical Association, and had served as secretary and president of the county society.

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**Joseph Charles Lill, M.D.**, of Fort Wayne, died January fourth at Fort Lauderdale, Florida. He was fifty-one years of age. Doctor Lill was a graduate of the St. Louis University School of Medicine in 1918. He had served as a member of the Fort Wayne Board of Health, and as a deputy coroner. He was especially interested in surgery. Doctor Lill was a member of the Allen County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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**Benjamin O. Shook, M.D.**, was killed December thirteenth, when his automobile was struck by a passenger train near his home. He was seventy-four years of age. Doctor Shook was a graduate of the Miami Medical College, in Cincinnati, Ohio, in 1902.

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**A. William Vogt, M.D.**, of New Alsace, died December third at Batesville. He was eighty-eight years of age, and had practiced his profession for the past sixty years. Doctor Vogt was a graduate of the Missouri Medical College, St. Louis, in 1884.

**Allen O. Dobbins, M.D.**, of Valparaiso, died January twelfth, at the age of seventy-five. He was a graduate of the Illinois Medical College, Chicago, in 1903. He served as coroner of Porter County, and also as county health commissioner. Doctor Dobbins was especially interested in pediatrics. He was a member of the Porter County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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**Elmo Ray Royer, M.D.**, of North Salem, died December thirty-first, at the age of sixty-nine. He was graduated from the Physio-Medical College of Indiana, in Indianapolis, in 1903. Doctor Royer was a veteran of World War I, having served as a major in the United States Army. He was a member of the Hendricks County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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**Silas Jackson Stottlemyer, M.D.**, of Anderson, died January third, at his home, at the age of sixty-five. He graduated from the Bennett College of Eclectic Medicine and Surgery, Chicago, Illinois, in 1911. Doctor Stottlemyer had served three terms as coroner of Madison County. He was a member of the Madison County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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**George Thomas Williams, M.D.**, of Crawfordsville, died December 30, 1944, at the age of seventy-nine. He was graduated from the Medical College of Indiana, Indianapolis, in 1887. Doctor Williams was a veteran of World War I, having served as a captain in the United States Army. He was especially interested in pediatrics. He was a member of the Montgomery County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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## THE MEDICS

"The 'medic' is a must in any fighting force. He is likely to combine the functions of Kipling's Gunga Din, Florence Nightingale, the Good Samaritan and the most skillful surgeon science has produced. He frequently does so at the cost of his own life. Unarmed stretcher-bearers seek out the wounded where the shells are still striking. Because they know that time is of the essence, they are always in a hurry. Sometimes a complicated operation has to be performed in a fox-hole, but they try hard to get the victim to the nearest hospital. Maybe it is a blasted barn or an open cellar. It may be a tent over the brow of the next hill, with the surgeons operating under enemy fire. At Bastogne two or three surgeons had to handle eight hundred patients with nothing to dull their pain but cognac. Everybody cheered when five more surgeons got through by plane and glider.

"There is little glory in the Medical Corps. It is just hard, dirty work and mighty dangerous. The Red Cross seems to mean little to the enemy. He has bombed hospital tents from Anzio to Aachen. These medics are tough, but among the torn and dying men learn to be tender, too. They shun glory, but they have their pride. They are proud to have saved ninety-seven out of every hundred wounded. They are proud that their miracle drugs and blood banks send from fifty to eighty back to fight again. They are proud because nobody in our whole vast Army, not even the foremost combat crew or the deadliest flying wing, has done a finer job than the Medical Corps."

The *New York Times*, January 5, 1945.

# POSTWAR HAPPENINGS TWENTY-FIVE YEARS AGO

(Items from THE JOURNAL of February, 1920)

Original articles included in this issue were: "Lipovaccines," by A. Parker Hitchens, of Indianapolis; "The Surgical Treatment of Empyema by a Closed Method," by A. E. Mozingo, of Indianapolis, and "Mastoiditis at Camp Taylor," by John W. Carmack, of Indianapolis.

* * *

The editor, Doctor Bulson, continued his attack on a Fort Wayne chiropractor, who had been accused of misrepresentation in his newspaper advertising.

Another editorial dealt with the income tax, as it concerned professional men.

The third editorial urged all physicians to interview their representatives in the Indiana General Assembly, on matters pertaining to medical law.

* * *

It was freely predicted that with the close of World War I there would be a large number of German physicians seeking licensure in this country, and it was recommended that the Federation of State Medical Boards watch their step.

* * *

The LaPorte County Medical Society was issuing a monthly Bulletin which carried a large amount of local advertising.

* * *

The Council of the Indiana State Medical Association had voted to close the office of the Executive Secretary, then located in the Hume-Mansur Building, Indianapolis. Fred Schortemeier, who had served in that capacity, was continued as legal counsel for the association.

* * *

A campaign was being inaugurated to more properly censor certain types of movie films, which were presumed to be of the eugenic variety.

* * *

The American Medical Association had made arrangements to hold its annual session at New Orleans, April 26-30.

* * *

"Flu" was still prevalent in Indiana and the proprietary manufacturers were "going to town" in their extravagant advertising, directly to the laity.

* * *

"Pay your dues, now," continued to be the editor's slogan. (Doctor Bulson was a leading exponent of the theory that it pays to pay dues exactly when they are due.)

* * *

Some medical journals were publishing pleas for financial assistance of "our starving colleagues in Germany and Austria." Editor Bulson was definitely opposed to any such donations.

A plea was made that all physicians interest themselves in postgraduate work, the charge being made that too many physicians had never indulged in such matters.

* * *

Most county medical groups had "upped" their fee bills, this to meet the marked increase in the cost of living.

* * *

Dr. B. Van Sweringen, Fort Wayne, had taken drastic steps to enforce the collection of a bill from an Indiana insurance company. He resorted to giving a full statement to local newspapers, in which he boldly declared that the company in question was not a safe company with which to do business.

* * *

Doctor Carlton B. McCulloch, Indianapolis, had announced his candidacy for the nomination for Governor, on the Democratic ticket.

* * *

Those having returned from military service were Ralph Arnold, Greenfield; Charles M. Gibbs, also of Greenfield, and J. F. Swayne, Clinton.

* * *

A new wing was being planned for the St. Elizabeth Hospital, at Lafayette.

* * *

Dr. Troy Earhart, who had been visiting the home folk at Mulberry, had returned to his post at the Ancon Hospital, Canal Zone.

* * *

Membership for 1919, according to the final report of Secretary Combs, was 2,563.

* * *

A Marine hospital was to be built in the Philippines, the first such hospital in the Orient, for the exclusive use of United States Marines.

* * *

The Indiana State Board of Medical Registration and Examination had elected the following officers: J. M. Dinnen, Fort Wayne, president; W. A. Spurgeon, Muncie, vice-president; M. S. Canfield, Frankfort, treasurer; and W. T. Gott, Crawfordsville, as secretary-treasurer.

* * *

The physicians of Marion were contemplating the erection of a building for medical men. It was said that this was prompted by a marked increase in the rental rates in that city.

* * *

The more than one thousand inmates of the Logansport State Hospital had been vaccinated against smallpox, this under an order of the superintendent.

# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION

### EXECUTIVE COMMITTEE

December 10, 1944.

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; J. T. Oliphant, M.D.; N. K. Forster, M.D.; J. E. Ferrell, M.D.; F. T. Romberger, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney, and T. A. Hendricks, executive secretary.

#### Membership Report

| | |
|---|---|
| Number of members December 9, 1944 | 3,395* |
| Number of members December 9, 1943 | 3,336 |
| Gain over last year | 59 |

** Includes 969 in military service and 126 honorary members.*

#### Treasurer's Office

(1) Dr. Weyerbacher reported that arrangements had been made with the George S. Olive Company for the annual audit of the books.

(2) Transfer of an additional $500.00 from the Medical Defense Fund to the Association's General Fund was approved upon the motion of Dr. Romberger, seconded by Dr. McCaskey.

Statements of receipts and expenditures for November for the association committees and THE JOURNAL were approved.

#### Holdovers from Special Meeting of House of Delegates, November 12, and Arrangements for Special Council Meeting, December 10, 1944

(1) The committee discussed the fact that it was evident that a disagreement existed in the minds of the profession as to just what action was taken by the delegates, and the committee felt that the Council should interpret just what action was taken. The general opinion of the committee was that according to the action taken at the special meeting of the House of Delegates, and by the resolutions and actions of the House on previous occasions, the state association is definitely obligated to a prepayment medical insurance program. The committee further felt that the House of Delegates, at its November meeting, left the way open for the new committee which is to be appointed to bring in a report for any form of an insurance plan as long as it is of an indemnity type.

(2) The committee discussed the publicity which appeared in the papers following the special meeting of the House of Delegates, and also various letters and comments received following the House of Delegates' meeting. These communications have been answered by the secretary, and the committee had nothing further to add.

#### 1944 Annual Session, Indianapolis

(1) A report is to be made at a later date by Dr. Bert Ellis, chairman of the local arrangements committee.

#### 1945 Annual Session, French Lick, Tuesday, Wednesday, and Thursday, October 2, 3, and 4, 1945

(1) Christmas greetings and commercial exhibit announcement to be mailed to exhibitors within the next ten days.

(2) Following are the rates at the French Lick Springs Hotel for the annual session:

Single rooms with bath, occupied by one—$13 per day, each.

Double rooms with twin beds and bath in deluxe section and in main and front section overlooking the gardens—$11 per day, per person, when occupied by two.

Double rooms with bath in old section on back of house—$10 per day, per person, when occupied by two.

Single rooms with lavatory and toilet, occupied by one—$10 per day, each.

Double rooms with lavatory and toilet—$9 per day per person, when occupied by two.

Rooms with running water only—$8 per day, per person, whether occupied by one or two.

The above rates are based upon the American plan and include all meals, as well as the banquet.

Charges are divided into quarter days, based on the following periods:

Arrival—

Before 9:30 A.M.—full day
After 9:30 A.M., before 2:30 P.M.—¾ day
After 2:30 P.M., before 9:00 P.M.—½ day
After 9:00 P.M.—¼ day

Departure (means actual time of leaving, baggage out, rooms released)—

After 7:00 A.M., before 11:00 A.M.—¼ day
After 11:00 A.M., before 4:00 P.M.—½ day
After 9:00 P.M.—full day

Rates for meals for persons not registered in the hotel are: $1.50 for breakfast, $1.50 for luncheon, and $2.50 for dinner.

(3) Hosts for the annual session are to be the members of the Orange County and the Third District Medical Societies.

As Major and Mrs. George Dillinger are not in French Lick, Dr. Forster was to discuss details concerning local arrangements with Dr. A. P. Hauss, New Albany, councilor of the Third District, who together with Dr. C. E. Boyd, West Baden Springs, will be the local convention co-chairmen.

**Legislative, Legal and Social Security Matters**

*National*

(1) Report made that Senator Wagner stated over the radio on the evening of Tuesday, December 5, that he would re-introduce his bill with certain changes.

(2) The following articles in regard to socialized medicine and the coming Congress were brought to the attention of the committee:

Editorial in *The Saturday Evening Post*, December 9, 1944

Article in *Fortune*

*Time* magazine.

(3) It is understood that Senator Pepper also is to have a bill, and is conferring with physicians concerning the details of the measure.

(4) Attention of the committee was called to Parts 2 and 5 of the Pepper hearings on Wartime Health and Education.

(5) *Other bills.*

a. The United States Public Health Service may have a bill.

b. Representative Dingell is asking the medical profession to help him draw up the medical features of his bill.

(6) Report made on the meeting of the Council on Medical Service and Public Relations in Washington, D.C., and the meetings of the old "Committee of 430," which is working under the title, "A Nation-wide Health Program."

*Local*

(1) *Inter-Professional Health Council.* Dr. Beatty made a report on the activities of the Inter-Professional Health Council. Among the subjects discussed at the meeting of the Council held December 4 were:

a. Codification of state health laws.

b. Veterinarians to have bill on Bang's disease.

c. The dentists are to strengthen their law in regard to advertising dentists and hygienists.

d. Pharmacists to have legislation which would maintain the educational standards of that profession.

e. Some regulation was suggested in regard to nursing homes.

f. The Indiana State Medical Association is to have a bill modernizing the State Board of Medical Registration and Examination.

g. The state medical association also is to sponsor a bill which would allow a physician to be a member of a county hospital board.

h. The state medical association is to work in opposition to the use of federal funds where state funds are available for public health work.

The next meeting of the Council is to be held January 12, and Dr. Beatty hopes that as many members of the Executive Committee can attend that meeting as possible.

(2) *State Board of Health.* The committee discussed the contemplated legislation of the State Board of Health.

(3) *Letterhead slogan against socialized medicine.* The following slogans were suggested:

DON'T SOCIALIZE MEDICINE.
WE DON'T WANT POLICITAL MEDICINE.
SOCIALIZE MEDICINE AND GET LESS SERVICE FOR MORE MONEY.

Other slogans are to be presented at the next meeting of the committee.

(4) Dr. John Hewitt discussed the subject of possible legislation and health activities that are to come before the next session of the legislature.

**Prepayment Medical Plans**

(1) The committee discussed various prepayment plans, including resolutions by the Montgomery County Medical Society, the action of the Ohio State Medical Association, a letter from the Medical Director of the Mayor's Committee on Medical Care, New York, a letter from Charles E. Foster, recording secretary of the International Union, United Automobile Workers of America, Chrysler Local No. 371, New Castle, Indiana, asking what progress was being made by the state medical association in developing Indiana prepayment medical plans.

**Organization Matters**

(1) Upon the motion of Dr. McCaskey, seconded by Dr. Romberger, it was moved that a new Council on Medical Service and Public Relations was to be organized in Indiana.

(2) Dr. Forster stated that his committee appointments would be ready for publication in the January issue of THE JOURNAL.

(3) *Letter from OPA Committee.* The Executive Committee expressed its appreciation for the work that has been done by the OPA Committee, and expressed a hope that this committee would continue to serve during 1945.

**Medical Economics**

Dr. Gatch, Dr. VanNuys, and Dr. Jewett appeared before the committee to discuss the recent directive from the Children's Bureau, which would make it obligatory for any hospital receiving crippled children to admit such children without the necessity of the children being referred by physicians. The committee recommended that an article concerning this directive be prepared for the January issue of THE JOURNAL.

**Future Meetings**

January 21, 1945—Midwinter meeting of the Council.

January 21, 1945—Secretaries' Conference.

February 10, 1945—Congress on Medical Service, Chicago.

February 11, 1945—National Conference on Medical Service, Chicago.

February 12-13, 1945—Congress on Medical Education and Hospitals.

February 13, 1945—Congress on Industrial Health.

There being no further business the meeting was adjourned.

## LOCAL SOCIETY REPORTS

### 100% IN PAYMENT OF 1945 DUES

BENTON COUNTY
JENNINGS COUNTY
LAGRANGE COUNTY
NOBLE COUNTY
ORANGE COUNTY
PERRY COUNTY
SWITZERLAND COUNTY
WASHINGTON COUNTY
WELLS COUNTY

### COUNTY MEDICAL SOCIETY OFFICERS

ADAMS COUNTY MEDICAL SOCIETY
President, Myron L. Habegger, Berne
Vice-president, Roland Reppert, Decatur
Secretary-treasurer, James M. Burk, Decatur

BARTHOLOMEW COUNTY MEDICAL SOCIETY
President, L. R. Crabtree, Columbus
Vice-president, Captain R. K. Schmitt, Columbus
Secretary-treasurer, Dorothy D. Teal, Columbus

BOONE COUNTY MEDICAL SOCIETY
President, R. J. Harvey, Zionsville
Vice-president, E. A. Rainey, Lebanon
Secretary-treasurer, John R. Porter, Lebanon

CLARK COUNTY MEDICAL SOCIETY
President, Ralph Bruner, Jeffersonville
Vice-president, David Pryor, Jeffersonville
Secretary-treasurer, Joel T. Carney, Jeffersonville

DECATUR COUNTY MEDICAL SOCIETY
President, Boyd Mahuron, Greensburg
Vice-president, H. S. McKee, Greensburg
Secretary-treasurer, J. T. Morrison, Greensburg

DEKALB COUNTY MEDICAL SOCIETY
President, Bonnell M. Souder, Auburn
Vice-president, Dorsey M. Hines, Auburn
Secretary-treasurer, Clayton B. Hathaway, Butler

GRANT COUNTY MEDICAL SOCIETY
President, E. C. Taylor, Upland
Vice-president, Claud E. Skomp, Marion
Secretary-treasurer, R. W. Lavengood, Marion

GREENE COUNTY MEDICAL SOCIETY
President, Frank A. VanSandt, Bloomfield
Vice-president, William F. Craft, Linton
Secretary-treasurer, George E. Moses, Worthington

HANCOCK COUNTY MEDICAL SOCIETY
President, Robert O. Scott, Charlottesville
Vice-president, Hiram T. Sexson, Greenfield
Secretary-treasurer, Joseph L. Allen, Greenfield

JACKSON COUNTY MEDICAL SOCIETY
President, G. R. Gillespie, Brownstown
Vice-president, L. H. Osterman, Seymour
Secretary-treasurer, G. H. Kamman, Seymour

JENNINGS COUNTY MEDICAL SOCIETY
President, W. H. Stemm, North Vernon
Vice-president, D. W. Matthews, North Vernon
Secretary-treasurer, John H. Green, North Vernon

KNOX COUNTY MEDICAL SOCIETY
President, E. L. Polloch, Vincennes
Vice-president, William Schulze, Vincennes
Secretary-treasurer, C. L. Boyd, Vincennes

LAGRANGE COUNTY MEDICAL SOCIETY
President, Clarence Schultz, Lagrange
Vice-president, Harley Flannigan, Lagrange
Secretary-treasurer, Alfred A. Wade, Howe

LAKE COUNTY MEDICAL SOCIETY
President, C. W. Yarrington, Gary
Vice-president, Ray Elledge, Hammond
Secretary-treasurer, H. M. Baitinger, Gary

LAPORTE COUNTY MEDICAL SOCIETY
President, Robert M. Kelsey, LaPorte
Vice-President, Robert W. Kepler, LaPorte
Secretary-treasurer, M. D. Gardner, Michigan City

MADISON COUNTY MEDICAL SOCIETY
President, H. E. Jones, Anderson
Vice-president, A. T. Jones, Pendleton
Secretary-treasurer, M. A. Austin, Anderson

MARSHALL COUNTY MEDICAL SOCIETY
President, A. A. Thompson, Tyner
Vice-president, C. R. Graham, Bourbon
Secretary-treasurer, L. W. Vore, Plymouth

NOBLE COUNTY MEDICAL SOCIETY
President, K. D. Sneary, Avilla
Vice-president, F. C. Hardy, Kendallville
Secretary-treasurer, F. W. Messer, Kendallville

ORANGE COUNTY MEDICAL SOCIETY
President, John Spears, Paoli
Secretary-treasurer, C. E. Boyd, West Baden Springs

PARKE-VERMILLION COUNTY MEDICAL SOCIETY
President, Paul B. Casebeer, Clinton
Secretary-treasurer, Richard J. Moran, Rockville

PORTER COUNTY MEDICAL SOCIETY
President, John F. Take, Valparaiso
Secretary-treasurer, John R. Frank, Valparaiso

PUTNAM COUNTY MEDICAL SOCIETY
President, V. Earle Wiseman, Greencastle
Vice-president, George F. Parker, Greencastle
Secretary-treasurer, George F. Parker, Greencastle

RUSH COUNTY MEDICAL SOCIETY
President, C. W. Worth, Milroy
Vice-president, F. H. Green, Rushville
Secretary-treasurer, W. S. Coleman, Rushville

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President, P. R. Tindall, Shelbyville
Vice-president, V. C. Patten, Morristown
Secretary-treasurer, J. A. Davis, Flat Rock

ST. JOSEPH COUNTY MEDICAL SOCIETY
President, C. C. Hyde, South Bend
Vice-president, F. W. Logan, Mishawaka
Secretary-treasurer, Kenneth L. Olson, South Bend

TIPPECANOE COUNTY MEDICAL SOCIETY
President, Frederick A. Loop, Lafayette
Vice-president, Edward T. Stahl, Lafayette
Secretary, J. C. Burkle, Lafayette
Treasurer, Charles Hupe, Lafayette

WELLS COUNTY MEDICAL SOCIETY
President, Harold D. Caylor, Bluffton
Vice-president, T. E. Caylor, Bluffton
Secretary-treasurer, H. Brooks Smith, Bluffton

WHITE COUNTY MEDICAL SOCIETY
President, J. P. Galbreth, Burnettsville
Vice-president, H. W. Greist, Monticello
Secretary-treasurer, H. B. Gable, Monticello

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Adams County Medical Society members held a meeting in the county hospital at Decatur on December twelfth. An election of officers was held.

*(Continued on Page xxv)*

*(Continued from Page 76)*

**Cass County Medical Society** members met with the members of the Woman's Auxiliary for dinner at the St. Joseph Hospital on December fifteenth. A business meeting was held following the dinner, and officers were elected.

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**Clark County Medical Society** members held a meeting at Jeffersonville on December twelfth. Dr. E. P. Buckley, of Jeffersonville, gave a report on the special meeting of the House of Delegates of the Indiana State Medical Association. Election of officers followed. Twelve members attended the meeting.

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**Decatur County Medical Society** members met at Greensburg, on December twentieth, this being the annual meeting for election of officers. Five members attended the meeting.

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**Delaware-Blackford County Society** members met at Hotel Roberts, in Muncie, on January sixteenth, to hear Edward Morris, Enrollment Director of the Indiana Blue Cross, who discussed "Indiana Blue Cross." Thirty members were present at the meeting.

---

**Elkhart County Medical Society** members held a meeting at Hotel Elkhart, in Elkhart, on January fourth. The speakers were Ed Cortas and A. L. Brown, who conducted a round-table discussion on "Sickness, Accident, and Hospitalization Insurance." Twenty members were present.

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**Fayette-Franklin County Medical Society** members held a dinner meeting, at Connersville, on December twelfth. Officers were elected for the ensuing year.

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**Fort Wayne (Allen County) Medical Society** members met with the Dental Society at the Chamber of Commerce Building, Fort Wayne, on December fifth. The speaker was Victor H. Hilgeman, D.D.S., who discussed "Cysts of the Jaws," and showed slides of x-rays. The meeting was attended by thirty members.

On January second another meeting was held at the Lutheran Hospital, in Fort Wayne, at which time staff doctors presented cases for discussion.

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**Greene County Medical Society** members met on December fourteenth at the home of Dr. K. L. Hull, in Bloomfield, for a dinner meeting. Business matters were transacted following the dinner. Ten members were present.

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**Knox County Medical Society** members met at the Jewel Cafe, in Vincennes, on January sixteenth. Fourteen members were present. Speakers were Dr. M. L. Curtner and Dr. Paul Arbogast, who discussed "Transverse Incision," and Dr. E. L. Pollock, who discussed "Placenta Praevia."


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**Hamilton County Medical Society** members met December twelfth at the Hamilton County Hospital. This was a dinner meeting, which was also attended by the hospital trustees and special guests. The business meeting included the election of officers for the ensuing year, and a discussion of plans for a new hospital.

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**Howard County Medical Society** members held a meeting on January fifth, at the St. Joseph Memorial Hospital, in Kokomo. Captain D. W. Paris, of Billings General Hospital, Fort Benjamin Harrison, discussed "Battle Wounds and Their Treatment." Fifteen members and two guests attended the meeting.

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**Indianapolis (Marion County) Medical Society** members met on January sixteenth at the Indianapolis Athletic Club. A Navy program was presented. Lieutenant Commander L. A. Schwartz, chief of the Neuropsychiatric Service, at the Naval Hospital at Great Lakes, presented a paper on "Introduction to Combat Fatigue"; Commander H. R. Houston, of the Naval Hospital at Great Lakes, had as his topic "Surgical Treatment of War Injuries"; and Lieutenant Commander D. H. Row, of the Naval Training Center at Great Lakes, discussed "Eye Examination as Conducted in the Navy."

On January twenty-third Dr. Raymond McNealy, Professor of Surgery at the Northwestern University School of Medicine, was the guest speaker at the medical meeting.

The third meeting, held on January thirtieth, included case reports given by Drs. C. H. McCaskey, Karl Ruddell, Walter Kelly, M. N. Hadley, and Walter P. Morton, all of Indianapolis.

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**Lake County Medical Society** members entertained their wives at a dinner meeting at the Woodmar Country Club, in Hammond, on December fourteenth. The wives of members now serving in the armed forces were honored guests. The business meeting included the election of officers, and the presentation of the Oberlin Award, for 1944, which was given to Mr. Charles W. Stiles, an official of the Carbon and Carbide Company, at Whiting.

The Oberlin Award is presented each year to the Lake County citizen or institution making the greatest uncompensated contribution to public health. This award was established in 1942, in memory of the late Thomas W. Oberlin, M.D., of Hammond, a charter member of the Lake County Medical Society.

One hundred twenty-six members and guests attended the meeting.

On January eleventh another meeting was held at Gary, where Captain L. T. Weiss, of Wakeman General Hospital, Camp Atterbury, spoke on "Maxillo-Facial Surgery and Facial Reconstruction." This was a joint meeting with the Northwestern District Dental Association, and more than one hundred members attended.

**LaPorte County Medical Society** members met at the Sheridan Beach Hotel, in Michigan City, on December twenty-first. "Ladies Night" was observed by entertaining the wives of members. Election of officers was held. The speaker of the evening was Dr. N. K. Forster, of Hammond.

Another meeting was held on January eighteenth, at the Rumely Hotel, in LaPorte, when Dr. John Dorsey, of Chicago, discussed "Carcinoma of Colon."

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**Miami County Medical Society** members held a meeting at Dukes Hospital, in Peru, on December twenty-ninth. The business meeting included election of officers for 1945, and plans were made for work to be done during the year. Seven members attended.

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**Montgomery County Medical Society** members met at the Culver Hospital, in Crawfordsville, on December twenty-eighth. The speaker was Dr. E. E. Richards, of Russellville, who discussed "Psychoneurosis in General Practice." Fifteen members and one guest were present.

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**Noble County Medical Society** members held a luncheon meeting December nineteenth, at the Publix Cafe, in Kendallville. Business transacted included election of officers for 1945. Eleven members attended the meeting.

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**Orange County Medical Society** members held a dinner meeting at the home of Dr. John K. Spears on December fifteenth. The usual business was transacted.

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**Porter County Medical Society** members held a meeting at Valparaiso, on November twenty-eighth, to hear reports on the special meeting of the House of Delegates of the Indiana State Medical Association, which were given by the president and the secretary. Twelve members were present.

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**Putnam County Medical Society** members met at Greencastle, on December fourteenth, with nine members present. Election of officers for the ensuing year was held. Nine members attended this meeting.

On January eleventh another meeting was held at Greencastle. Nine members and two guests were present.

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**Randolph County Medical Society** members met at Winchester, on January eighth, to hear Dr. Harry Nieman, of Dayton, Ohio, who gave an illustrated talk on "Common Skin Diseases." A discussion followed in which thirteen members and two guests participated.

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**St. Joseph County Medical Society** members held a meeting at the Indiana Club, on December twelfth, to elect officers for the following year.

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1. Sperling, L., Weisman, S. and Papermaster, R.: Surgery, *11*:600-604 (April) 1942.
2. Boyer, N. H.: J.A.M.A., *122*:306-309 (May 29) 1943.
3. McMahon, A. and Nussbaum, R. A.: So. Med. Jl., *33*:1127 (Nov.) 1940.

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

**Shelby County Medical Society** members held a meeting at the Major Hospital, in Shelbyville, on January third. The speaker, Dr. Victor Vollrath, of Shelbyville, had as his subject "Low Spinal and Caudal Anaesthesia in Obstetrics." Nine members attended.

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**Tippecanoe County Medical Society** members met on December twelfth, in St. Elizabeth Hospital, at Lafayette. Dr. E. N. Kime, of Indianapolis, discussed "Importance of Fascia, Tendons and Infections about Face and Retroperitoneal Regions." Fifty members attended the meeting.

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**Vanderburgh County Medical Society** members held a meeting on December twelfth, at the Hotel Vendome, in Evansville. Dr. E. H. Weber, director of school health and physical education in Evansville, gave a report on the physical fitness of high school boys. Election of officers for 1945 concluded the business.

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**Wayne-Union County Medical Society** members held a joint meeting with the Richmond Dental Association on November thirtieth, at the Richmond Leland Hotel, in Richmond. G. T. Gregory, D.D.S., of Indianapolis, discussed "Oral Pathology and Its Relation to both the Medical Profession and the Dental Profession." After the dinner, a short business meeting was held.

Another meeting was held on December fourteenth, at Richmond, at which time a sound motion picture, from Harvard University Medical School, on "Angina Pectoris," was shown. Eighteen members were present.

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## COUNCIL APPOINTS COMMITTEE ON PREPAYMENT OF MEDICAL AND SURGICAL CARE

The appointment of the following physicians, by Dr. J. T. Oliphant of Farmersburg, president 1944, and Dr. N. K. Forster of Hammond, president 1945, as members of the Committee on Prepayment of Medical and Surgical Care of the Indiana State Medical Association was approved by the Council at its meeting today in the Claypool Hotel:

Drs. W. U. Kennedy, New Castle, chairman; Robert Acre, Evansville; C. Phillip Fox, Washington; Claude Dollens, Oolitic; I. M. Sanders, Greensburg; M. C. Topping, Terre Haute; Joseph L. Allen, Greenfield; Marlow W. Manion, Indianapolis; Bruce Stocking, Muncie; Wemple Dodds, Crawfordsville; J. Robert Doty, Gary; G. M. Nie, Huntington; H. D. Brickley, Bluffton; F. R. N. Carter, South Bend; Robert Masters, Indianapolis; Lyman T. Meiks, Indianapolis; F. S. Crockett, LaFayette; W. H. Howard, Hammond; A. J. Sparks, Fort Wayne; Walter L. Portteus, Franklin; and A. P. Hauss, New Albany.

This special committee is to report in detail an insurance plan or plans for consideration of the House of Delegates at a future meeting.

Dr. Floyd T. Romberger, of Lafayette, was re-elected chairman of the Council for 1945. Dr. Cleon A. Nafe and Dr. Carl H. McCaskey, both of Indianapolis, were re-elected to serve as members of the Executive Committee of the association for 1945.

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## *WOMAN'S AUXILIARY to the Indiana State Medical Association*

**President—Mrs. F. M. Gastineau, Indianapolis**
**President-elect—Mrs. S. J. Petronella, East Chicago**
**Corresponding Secretary—Mrs. C. L. Bock, Indianapolis**
**Treasurer—Mrs. A. W. Ratcliffe, Evansville**
**Press and Publicity—Mrs. A. B. Richter, Indianapolis**

---

### ALLEN COUNTY

Approximately sixty members of the Allen County Medical Auxiliary attended a Christmas party given December fifth at the home of Mrs. W. O. McBride, in Fort Wayne. Special guests were Mrs. F. M. Gastineau, of Indianapolis; Mrs. C. E. Munk, of Kendallville; Mrs. Arnold H. Duemling, of Fort Wayne, and wives of medical officers stationed at Baer Field.

The program included music and the reading of a Christmas play. Mrs. Elmer Singer was general chairman of the meeting.

Members of the Allen County group were in charge of a Christmas Seal booth in one of Fort Wayne's leading stores for one week shortly before Christmas. Mrs. M. B. Catlett was chairman for this project.

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### DELAWARE-BLACKFORD COUNTY

Mrs. U. G. Poland entertained twenty-three members of the auxiliary at her home, in Muncie, on December nineteenth. This was the annual Christmas luncheon meeting. Mrs. F. M. Gastineau, president of the auxiliary to the Indiana State Medical Association, was the guest speaker.

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### LAKE COUNTY

On November twenty-fifth Mrs. Carl L. Bendler, of Gary, entertained the Gary and south branches of the Lake County Medical Auxiliary at her home. This was the annual Christmas party for the group. Each guest brought a box of Christmas cards which were sent to wounded veterans at Camp Atterbury for their personal use.

The auxiliary was the guest of the Lake County Medical Society on December fourteenth, at the Woodmar Country Club. This dinner was the annual "Oberlin Award" gathering of the Lake County doctors, and the wives of medical men in service were the honored guests.

### MADISON COUNTY

A November meeting of the Anderson Auxiliary was held November twentieth, at the Y.M.C.A. Mrs. Guy Ross presided at this dinner meeting. Mrs. Wayne Elsten reported on the recent state meeting. Mrs. F. M. Gastineau talked informally to the group regarding the recent conference held by the national officers, and their program plans in relation to the postwar world.

### VANDERBURGH COUNTY

A luncheon and social meeting was held at the Montgomery-Spence tea room on November fourteenth, in Evansville.

### VIGO COUNTY

An all-day meeting was held at the home of Mrs. C. R. La Bier, on November thirteenth. Luncheon was served at noon. The members sewed for the Red Cross.

Personal item: Mrs. L. A. Malone, of the Vigo County Auxiliary, spoke on "Occupational Therapy in Local Hospitals" at a meeting of the Kent Avenue Woman's Club on November fifteenth.

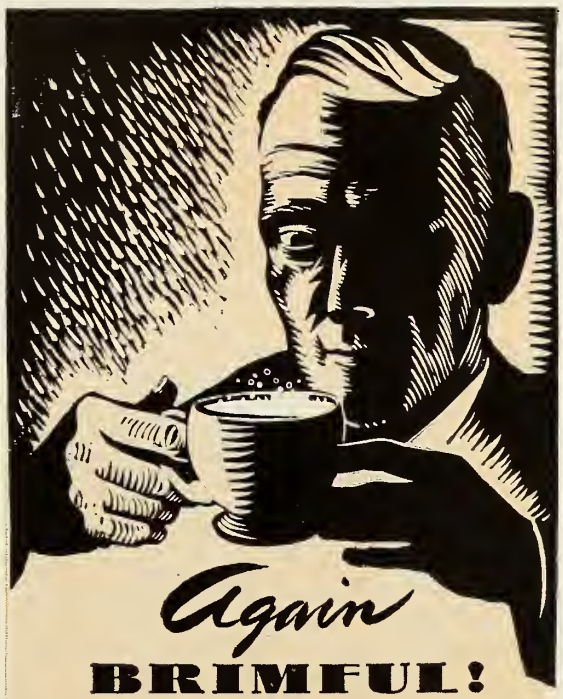
A rummage sale was held by members of the Vigo Auxiliary on December eighth.

## INDIANA STATE BOARD OF HEALTH

### DIVISION OF COMMUNICABLE DISEASE CONTROL

**Monthly Report—December, 1944**

| *DISEASES* | *Dec. 1944* | *Nov. 1944* | *Oct. 1944* | *Dec. 1943* | *Dec. 1942* |
|---|---|---|---|---|---|
| Chickenpox | 506 | 278 | 90 | 222 | 342 |
| Measles | 25 | 19 | 13 | 460 | 178 |
| Scarlet Fever | 514 | 266 | 137 | 239 | 195 |
| Smallpox | 4 | 3 | 2 | 3 | 20 |
| Typhoid Fever | 1 | 6 | 11 | 3 | 4 |
| Paratyphoid Fever | 1 | 0 | 0 | 0 | 0 |
| Whooping Cough | 42 | 44 | 42 | 92 | 71 |
| Diphtheria | 63 | 32 | 40 | 32 | 24 |
| Influenza | 37 | 19 | 9 | 2,431 | 47 |
| Pneumonia | 4 | 4 | 10 | 42 | 109 |
| Mumps | 89 | 56 | 18 | 74 | 189 |
| Cerebrospinal Meningitis | 14 | 14 | 12 | 25 | 9 |
| Nonepidemic Meningitis | 1 | 4 | 0 | 1 | 0 |
| Undulant Fever | 8 | 7 | 4 | 3 | 2 |
| Erysipelas | 1 | 0 | 0 | 0 | 0 |
| Tularemia | 27 | 1 | 1 | 5 | 8 |
| Rubella | 6 | 2 | 0 | 120 | 33 |
| Rabies in Man | 1 | 0 | 0 | 0 | 0 |
| Septic Sore Throat | 2 | 0 | 3 | 0 | 0 |
| Shigella Dysentery | 1 | 0 | 0 | 0 | 0 |
| Infectious Jaundice | 1 | 0 | 0 | 0 | 0 |
| Impetigo | 5 | 2 | 4 | 0 | 0 |
| Vincent's Angina | 1 | 0 | 0 | 0 | 23 |
| Tuberculosis, Pulmonary | 324 | 264 | 327 | 300 | 870 |
| Tuberculosis, Other Forms | 14 | 9 | 15 | 37 | 9 |

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## IMPORTANCE OF PREVENTIVE MEDICINE

War always spotlights the dramatic role played by surgery and medicine. Less frequently does some unusual situation shift the spotlight to the highly important role played by preventive medicine as, for instance, when our troops landed in the Philippines. There they found that the civilian population had suffered woefully for lack of a preventive medicine program, under Japanese domination. Sanitation had deteriorated. Food was inadequate. Great numbers of the people were suffering from tropical ulcers, jaws, intestinal diseases and vitamin-deficiency diseases. They were endangered by cholera, smallpox and typhoid fever. Now, with the return of our troops, preventive medicine is again being practiced in the islands. Carrying out plans prepared by the Civil Public Health Division of the Preventive Medicine Service, Office of The Surgeon General, sanitation is being restored. The people are being immunized against diseases. Health offices have been re-established in the majority of communities wrested from the Japs, and dental clinics, dispensaries and hospitals have been established.

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# THE JOURNAL

OF THE

# INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

*ISSUED MONTHLY under Direction of the Council*

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 38 MARCH, 1945 Number 3

## A MEDICAL VIEWPOINT ON NATIONAL FITNESS

J. W. WILCE, M.D.*

COLUMBUS, OHIO

The Physical Fitness Program, to improve the health and fitness of the American people, appears to be one of the most *real* challenges to come to organized medicine in many years.

The practical working out of a national fitness program presents a complicated picture. It is not so complicated as to prevent extremely constructive results, granted intelligent "team play," mutual tolerance, and calm working out of conflicting attitudes, motivations, and methodologies. The draft statistics posed the problem.

Excellent military results and fine industrial production, to say nothing of super athletic performance by 4F's, argue that, practically, we are not so badly off as appeared on the surface. It is fallacious to say that we as a nation are less healthy today than formerly.

The unscientific political use of draft statistics in an attempt to modify, radically, existing medical practice and proud tradition may become apparent in the current scene.

Few will argue that certain changes to broaden the base of medical practice are not desirable. Many constructive changes and revised attitudes have already been effected in the best American tradition from within the medical profession, as is evidenced by the presence and increasing acceptance of newer medical practice plans.

Radically socialized state medicine is *not* prerequisite to an adequate fitness program. The health-minded general physician on the local level is one of the most essential factors to the success of the movement. Physicians in general, on the home front, are probably more overloaded than many other groups involved in the manpower shortage. The honorable, vital participation of the younger, most fit members of the profession in military medicine in this great war is a source of pride to the profession and the country.

While this fitness movement may have its start under conditions of tremendous medical overload, it must be conceived in the light of the possibilities of its future development, when the younger men return, eager to resume, re-develop, or begin their practices. Examination of masses and their guidance as to fitness for activity may present legitimate opportunity.

### WHAT IS FITNESS?

National fitness will not be achieved in any revolutionary way, because it is a "quality of life" based fundamentally on individual variables of hereditary, environmental, economic, sociological, psychological, medical, physical, religious, and educational factors.

Fitness in a general current sense might be described as that quality of human life that makes for: (1) optimum of good feeling and capacity to enjoy living at any age; (2) optimum of productive capacity and service; and (3) the attainment or maintenance at proper ages of those medical, physical, mental, and moral standards judged necessary as qualifications for participation in the defense of our freedom.

The attainment of such national fitness is a big order, but some believe that it is not a completely unattainable ideal. Obviously, such a program must be aimed at fitness throughout the span of life from conception to death, and not at a special age group.

It is natural that individuals and groups think of this movement in the light of their own connection with it. The opinion of the medical group is fundamental, because this is the group most qualified by training to guide a total picture.

* University Health Service, Ohio State University, Columbus 10, Ohio.

### CURRENT STATEMENTS OF MEDICAL LEADERS

Dr. Morris Fishbein is the authority for the statement that, "It is important for the medical profession to say as Dr. Roger Lee and Dr. Harvey Stone both said in their appearance before the Pepper Committee, that the medical profession is assuming the leadership in raising the people of the United States to a high degree of health and physical fitness." [1]

Doctor Fishbein gave a streamlined picture of the project in his *Hygeia* editorial, "The Health of American Youth," when he wrote: "An analysis of the situation, as it relates to the physical fitness of American youth, indicates that the problem demands a multiple approach."

"Improvement of physical fitness must begin even before birth, with proper prenatal care; extend through infancy with an immunization program that might prevent infectious diseases of childhood and their crippling complications; go on through the nursery and kindergarten where sound habits of nutrition begin to be established; and carry through grade school, high school, and college, in which sound instruction in health habits and physical activities, including competitive sports, should be integrated in the curriculum. Finally, when the boy or girl has left school there must be continuing participation in healthful living, sports, and recreational pastimes to maintain the physical fitness that the schools have established. The development of such a program demands a nationwide participation, and depends, for its success, on the cooperative efforts of physicians, and all the accessory medical professions, physical educators, health educators, industry, and the general public." [2]

Dr. Olin West states, "We want to keep medicine in the forefront of this movement, not only in a purely advisory capacity, but in an authoritative advisory capacity. I do not believe that the movement can ever succeed unless it is largely directed by medicine, and I am sure that it can never succeed unless the profession on the state and local level will get wholeheartedly into the movement." [3]

Dr. Leonard Rowntree, chairman of the Joint Committee on Physical Fitness, and medical director of Selective Service, believes, "The task of medicine will center around the recognition, prevention, and correction of defects, deficiency, disability, disorders, and diseases." [4] The entire article from which Doctor Rowntree's quotation is taken, titled, "Physical Fitness for America," should be read by every physician or layman who plans to understand the movement.

It was my privilege to address the last annual conference of State Society Editors and Secretaries, at the invitation of Doctor West, on the subject, "Medical Attitudes, Opportunities, and Responsibilities in a National Fitness Program." Most of the material, with discussion, is published in a recent issue of *The Journal* of the American Medical Association.[5]

It is stimulating to know that the seed recently planted is developing, and that THE JOURNAL of the Indiana State Medical Association is devoting this entire issue to the promotion of the fitness campaign, and to the ideas of medical and other leaders.

### CURRENT MEDICAL LEADERSHIP

As stated to the editors and secretaries, "The basic responsibility of medicine is to participate to the limit of its great influence, through its every channel and medium, in the fundamentally sound aspects of the program on all levels."

On the national level this has meant that the seven outstanding A.M.A. representatives, in cooperation with an equal number of lay members, have worked since June, 1944, on the policies and program and methodologies of the Joint Committee. It has meant that eight physicians, chosen by A.M.A. authorities, have spent varying degrees of time working as co-chairmen with lay chairmen in getting up programs in eight major areas, which have been submitted to the Joint Committee.

Medical and other Joint Committee members have written well concerning the movement. It means, to the best of my knowledge, that the National Research Council, Division of Medical Sciences, is working on proper standards of medical and physical fitness, at the request of the Joint Committee. The sub-committee of Allied Industry, Publicity, and Promotion appears to be waiting for this and other fitness material. Such material, with other fine material originated in this committee, would be given public spread and distribution through subsidies provided by this fine group. Organized medicine, state and local, will profit from the research findings.

No group anywhere will be able to give final answers to fundamental fitness questions, such as the effect of intensive exercise on the total health picture of individuals with varying organic endowments and medical histories. A controlled medical study of such type has never been made. Several long-time projects of this type are in process, but it will probably take twenty-five years or more to get significant information.

The intelligent study of military medical histories, records, and discharges gives the greatest promise of early usuable information, to supplement the extensive clinical and previous investigative experience of physicians. A study by a private group at a naval preflight school should be valuable. Sample medical inventory programs are accomplished and others are in process.

The campaign is progressing on the national level with promise, but is still in the very neces-

[1] *J.A.M.A.*, January 27, 1945, p. 228.
[2] *Hygeia*, December, 1944, p. 895.
[3] *J.A.M.A.*, January 27, 1945, p. 229.
[4] *Hygeia*, October, 1944, p. 745.
[5] *J.A.M.A.*, January 27, 1945, pp. 227-30.

sary stage of food-gathering, mastication, and very early digestion, in the higher councils.

MEDICAL RECONSIDERATION OF STATE ORGANIZATION DESIRABLE?

There seems to have been some slight difference of opinion concerning state organization for fitness. With 264 national organizations interested in the movement, this is natural.

Speaking to the editors and secretaries, I recommended that "Medicine should attempt realistically to change the national, state, and local organization to achieve a national, state and local organization deemed best from the medical standpoint for the continued and improved achievement of medical and physical fitness ends." [6]

More than thirty-seven states have functioned, some very successfully, for about two years with state committees. Those committees were formed with the cooperation of state agencies through stimulation of government agencies; first, the Office of Civilian Defense; and later, the Federal Security Agency, before medicine was invited, and before the new principle of national organization, as illustrated by the Joint Committee, was established.

MEDICAL INITIATIVE NEEDED

The policy of the Joint Committee seems to be that states organize, but organize as they please, without attempting to suggest other than general organization patterns. That policy places the initiative directly up to state medical organizations, if they care to attempt to modify current state organization to the type they consider satisfactory for their full participation. In some states their present organization may be entirely satisfactory.

If the objective of the present movement is primarily physical fitness through exercise, recreation, and safety, the present state organization may be satisfactory. However, this approach was proved incorrect after the last war.

If the objective is a program to improve health and fitness from conception to death, physicians should have a much greater place of authoritative advisory type in the state and local fitness or-

[6] *J.A.M.A.*, January 27, 1945, p. 228.

## PHYSICAL FITNESS THROUGH SPORTS

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Congratulations to THE JOURNAL of the Indiana State Medical Association for devoting this issue to "Physical Fitness."

The topic of "Physical Fitness" is now of tremendous importance. Selective Service exposed the faults of the past and revealed that even though the youth of the country evidenced an interest in physical fitness through competitive sports, there was a lack of direct action. There is now a realization of the lack of sufficient supervised programs for the youth, and no program at all for adults.

Even schools, which were the foundation of what physical fitness the nation had, were leaning too much toward specialists, and did not realize sufficiently the value of competitive sports for all students. Every state and every community in the state should be made to realize the value of physical fitness through sports for all members of the community on the level on which they are able to participate. A program of this type might well supplant the present contemplated compulsory military training.

Physical fitness is the primary requisite of all military training. The military could be handled by a large standing army, well schooled in modern methods of warfare. If the military leaders feel, after thorough investigation, that physical fitness alone is not sufficient for the welfare of our country, some classes in mechanics or other subjects could be given over a period of time without taking a full year out of a boy's life for straight military training.

Such a Physical Fitness Program should be based on all boys, physically able, participating in some form of competitive sport in the school. Playgrounds and industry could be enlisted to institute and maintain greater athletic programs. A well-knit program conducted in these institutions will lead to lessons applicable to life, as well as the physical fitness so essential to military training. The program, of course, must be under proper physical and medical supervision. This will afford jobs for many returning veterans, without the increase in federal taxes inescapable in a government-inspired program.

ganizations. They should guide the over-all health picture in close cooperation with all other groups and interests, recognizing fully the broad nature of the movement and the fine contribution possible from all groups.

The principle of equal, or at least adequate, numerical medical representation on state organization similar to the Joint Committee in national organization seems sound. It may be necessary to insure the fullest participation of medical groups on the state and local level.

Desirable state organization might include, at least during the war, a military medical chairman, who should be a retired but an active officer experienced in Selective Service. If such a man is not available, the president of the state medical association might well lead a central committee of seven to ten top physicians, including medical heads of state public health, and seven to ten top figures in education, business, labor, and the American Legion. A large general advisory and program-suggestion and support-group should supplement the central committee. The state fitness committees would be responsible to the Governor, as is the case with the present committees.

I am personally convinced that the above Joint Committee basis of state organization would bring about better results for all interested groups.

It is necessary for every interested group to appreciate the capacity for contribution of every other group, and to tolerate the unavoidable overlapping of authority and differences of opinion. Many physicians and laymen resent the arguments which suggest that the draft statistics are bad; therefore, we must have more physical education and recreation to correct this situation.

We must have increases in these fields, but physicians and others who have studied this matter are convinced that more outstanding needs are for the broadest public health and private medical service—more examinations, more adequate examinations, intelligent and courageous guidance to appropriate activity and diet, and improved machinery for the correction of correctable defects.

The latest definite evidence regarding the place of physical education in the field is that advanced by Henry F. Mace, M.D. He concludes from a small sampling in Albany schools that "Physical education training perhaps has had less to do with rejections than has been usually thought." [7] I take it that he means with preventing rejections.

In my opinion, the experience of many physicians in seeing poor medical and surgical results from physical activity may explain the lack of enthusiasm for sport and physical education shown by some. The constructive phases of well-conducted sport, physical education, and recreation should be freely supported and promoted by physicians.

### CURRENT CONSERVATIVE SUGGESTIONS

Much has been done and is in process of being done in many fields because of Joint Committee stimulation and state and local initiative.

The great immediate need in fitness seems to be that of added stimulation of the Industrial Health field. It would seem appropriate that state industrial medical committees and local academies of medicine should continue to take steps to initiate, support, and strengthen efforts in the field of improved total health of employees. Medicine should be assigned total health guidance in this field, responsible to high personnel and management.

Strengthening the immediate war effort and individual worker advantages are the most important considerations.

The second immediate need seems to be the strengthening of school health, on the high school and pre-military college level. This involves the finding and stimulating of a desire for correction of correctable defects in the immediate pre-military age. Exercise of the physical-hardening degree, to ease the individual's adjustment to basic military training, is a secondary but important consideration. The high school victory program has functioned with some results.

The inclusion in state and local medical meetings of programs and exhibits and round tables on medical as well as physical aspects of total fitness seems desirable, even at this stage.

Medicine should encourage necessary self-education in the fitness field, and participate in examination programs, stressing the health viewpoint. It is inappropriate to advocate further methods of individual participation in this program at this time.

Logic suggests that state associations request from the parent organization practical suggestions as to how they might proceed further. I have ideas on the subject, but know that only a meeting of the sub-committee on medical affiliates can officially propose a program for state and local medical units.

On the national level, it is my personal opinion that the A.M.A. should add a definite fitness executive secretary, who should be a physician. He might serve as co-executive secretary to the Joint Committee. He would be able to present the medical point of view, could bring together the fine material available, and service the states in medical aspects of fitness, as the A.M.A. Health Education Office now functions in that field.

Until further official guidance and strategy is available, individual thinking and participation under present organization is, of course, appropriate.

It should be understood that opinions expressed in this brief article are personal and not official.

If these suggestions stimulate further thinking on the part of any of the thousands interested in the coordinated fields of national fitness, they will have served their purpose.

[7] *J. of School Health*, November, 1944, p. 216.

# RECOVERY AND CURE FOR AMERICA'S PHYSICALLY UNFIT

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Editor of *The Journal of the American Medical Association*

CHICAGO, ILLINOIS

The people of the United States spend more money for recreation than the people of any other nation in the world. More than $22,000,000,000, or one-fourth of the national income, is spent for recreational motoring, congenial eating, motion pictures, fiction, radio, vacations, and travel. Each year there are 40,000,000 admissions to baseball games, 10,000,000 to football games, and 5,000,000 viewing golf, tennis, boating and similar sports. While these recreations are healthful, particularly from the mental point of view, and while they help to pass the time, they are not significant except in an inspirational way for physical fitness. The people of the United States need to learn the relative values of various forms of recreation and the objectives to be sought.

The physicians of the United States have an important role in any physical fitness campaign. First, theirs is the responsibility for inventory before and after a physical fitness program to determine the nature of the difficulties to be overcome, and then to determine how well the result has been accomplished. Such preliminary inventories as have already been made—notably the one in the schools of Cincinnati, those at the University of Illinois, and at the University of Michigan—have already proved that physical fitness programs pay high dividends.

At the University of Michigan a physical conditioning program, consisting of four and one-half hours each week, of supervised calisthenics, obstacle racing, mass combat activities, rough-and-tumble activities, and competitive sports was provided to one thousand men whose physical condition had been ascertained before the program was begun. In general, the physical fitness was improved by at least 20 per cent with the completion of one term of this hardening course. The men changed their condition from "unsatisfactory" to "satisfactory." Furthermore, the amount of gain was directly proportionate to the amount of time spent in the conditioning course. A group of 262 students who used only three hours per week did not improve as much as those who spent the full four and one-half hours. Furthermore, you have to like physical fitness in order to achieve it. A group of men who disliked physical fitness work gained only about one-fifth as much as those who liked it.

The purpose of a physical fitness campaign is not the development of big muscles or of extraordinary endurance. Physical fitness implies that the heart, lungs, teeth, eyes and other organs are physically sound and capable of working efficiently. Physical fitness implies the ability to do hard muscular work and to produce sudden bursts of energy and long-sustained effort. Physical fitness implies, finally, specific fitness or skill in certain performances. In the armed forces physical fitness is geared to make the man capable of meeting any demands that may be placed on him. But physical fitness is needed not only by our students and by the men in our armed forces, but by every man and woman in the country, particularly in times of total war. Especially is physical fitness needed in industry where the man's fitness must be geared to a specific job.

More and more industries in the United States are beginning to require complete physical examination as a condition for employment. The Council on Industrial Health, of the American Medical Association, working with representatives of management and of labor, has developed a form for determining the physical condition of workers and for maintaining continuous records of the study of the workers' health and fitness.

About one-fourth of the prospective employees of the Eastman Kodak Company are rejected because of deficiencies of vision, and more than 13 per cent because of deficiencies of the heart. Our Army and Navy rejected 6.3 per cent of the applicants because of mental or nervous unfitness. This type of fitness must also be included in any comprehensive program for improving the general health of the nation.

The Joint Committee of the American Medical Association and the National Committee on Physical Fitness, which on September 1, 1944, began an intensive program for physical fitness, represents the devotion of the knowledge that medicine has gained about life and health, and that experts in the field of physical education and recreation have developed to overcome many of the preventable and correctable defects that were responsible for two-thirds of the rejections of men who were unable to meet the needs of the armed forces. Physical fitness is not a matter, as I have said, of muscles alone. It includes the practice of good personal hygiene and the application of established knowledge to improving the health and fitness of the human body. It includes enough sleep, the right kind of ventilation, and continuous emphasis on cleanliness. It demands proper nutrition, good posture, controlled exercise, and rest. It embraces mental hygiene and a program of recreation. When all of these ingredients are included in a scientifically-compounded prescription, the result is *recovery and cure* for America's physically unfit.

# FITNESS FOR DUTY OF MILITARY PATIENTS ON DISCHARGE FROM HOSPITAL

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Unlike civilian medical practice, the military patient on discharge from the hospital must of necessity be capable of performing a full day's duty, whether it be in a training or combat unit. Training demands and military manpower needs at one time were such that "non-effective rates" in the field units were alarmingly high because too many soldiers in training were being readmitted to hospitals for no other reason than physical unfitness for the training requirements. Circumstances in an accelerated training schedule demanded by the war permitted no limited or light duty assignments on discharge from hospital. During 1943, the Medical Department of the United States Army was confronted with a serious problem. Particularly concerned with this problem were the station hospitals. However, on closer analysis it was found to apply to all military hospitals.

Keenly aware of this situation, Major General Norman T. Kirk, on assuming the office of Surgeon General of the United States Army, directed that all soldier patients be reconditioned, physically and mentally, prior to discharge from a hospital. He further directed that those patients discharged to civilian life because of physical disability be conditioned to the optimum commensurate with the individual disability. The President directed on December 4, 1944, that the disabled members of the armed forces returning from overseas be provided with pre-vocational training and vocational guidance prior to their separation from the military service.

As a result of these directives the Convalescent Reconditioning Program has been developed and is now in operation in all Army Service Forces hospitals. It might be more accurately stated that two programs are in operation, one designed primarily for those cases in which return to a duty status is expected, considering the nature of the disease, wound or injury, and the other in which return to civilian life is obvious because of serious and permanent disability. The former is applicable to all hospitals in the Continental United States, but mainly to the station and regional hospitals, whereas the latter today fits the greatest number of patients in general and convalescent hospitals. Similarly, programs are in operation in all overseas theatres.

The Reconditioning Program provides a well-balanced plan of convalescent care, consisting of physical, educational, and occupational conditioning. The program is flexible, adjusting to the particular needs of the type of patient, or his disability, and provides ample opportunity for recreation. The bed patient will have more educational reconditioning and occupational therapy, whereas the patient being prepared for return to duty and most fit will have a strictly military program, emphasizing physical conditioning. The program is arranged at four levels of activity, each designed for a certain level or stage of convalescence: Class 4, the bed and chair stage; Class 3, the ward ambulant stage; Class 2, the ambulant stage not requiring the daily attention of the ward surgeon; and Class 1, the ambulant stage nearest the perfection of fitness for full military duty.

Confining the subject matter to the title of this paper, a discussion of the Class 2 and 1 program, and its results, will be stressed. At the present time the largest group of patients to which this advanced convalescent reconditioning applies will be found in the station and regional hospitals. Patients whose stay in the hospital has been so brief as not to permit any appreciable loss in condition are returned directly from the ward to their organizations, while all others who may be expected to return to duty are assigned to the Advanced Reconditioning Section. The Advanced Reconditioning Section serving a hospital is located in barracks detached from the hospital wards proper. This transfer is desirable in order to impress upon the convalescent soldier that he is not an invalid, and that he is well on the way to complete recovery and capable of participating in prescribed activities leading to optimum restoration of health and strength. It is further desirable that the convalescent soldier be discharged physically fit for the performance of full military service. To this end the convalescent soldier assigned to the Advanced Reconditioning Section is known as a trainee. Although he is still classified as a patient, he is granted all the privileges normally enjoyed by a soldier on a duty status.

A recommended program for patients assigned to Advanced Reconditioning Sections has been approved by The Surgeon General and the Director of Military Training, Headquarters, A. S. F., and distributed to all hospital commanders in accordance with the provisions of A. S. F. Circular No. 217, 1944. It is intended that this program be rotated each four weeks, as it has been found that the maximum stay of a patient in the Advanced Reconditioning Section is usually less than four weeks. Some patients progress more rapidly than

others, and no patient will be retained in a hospital beyond the time required to condition him for fitness for his assigned duties. Under this program two hours daily are devoted to academic instruction in basic military subjects common to all the arms and services. In this four-week program hours are devoted to subjects as follows:

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| Indoctrination, orientation, and mental hygiene | 12 hours |
| Map reading | 8 hours |
| Field sanitation | 6 hours |
| Weapons and their uses | 4 hours |
| Defense against air and mechanized attack | 4 hours |
| Time reserved for the commanding officer | 4 hours |
| First Aid | 3 hours |
| Safeguarding military information | 2 hours |
| Personal and sex hygiene | 2 hours |
| Scouting and patrolling | 2 hours |
| Organization of the Army | 1 hour |

The time reserved for the commanding officer is to be utilized for instruction in military subjects selected by the commanding officer of the post, to best suit the needs of the patients who are assigned to the Advanced Reconditioning Section. For example, at a post where the Signal Corps Replacement Training Center is the main unit station, Signal Corps subjects will be stressed. At a post where an Infantry Division is stationed, subjects will be selected which will best suit the needs of that unit, et cetera.

This is not military training in the strict sense of the word. It is not intended to qualify the soldier for a military occupational specialty, but rather to provide direction to his convalescent training—to bring to him a sense of accomplishment and, in so doing, to re-establish the confidence and courage necessary for successful return to military life.

The remainder of this program is devoted to Physical Reconditioning, with hours allotted to activities as follows:

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| Marches | 28 hours |
| Athletics and games | 20 hours |
| Gymnastics | 16 hours |
| Occupational therapy or work therapy | 15 hours |
| Dismounted drill | 10 hours |
| Calisthenics | 8 hours |
| Physical fitness tests | 7 hours |
| Medical examinations | 6 hours |
| Running | 5 hours |
| Obstacle course | 3 hours |
| Combatives | 3 hours |

The Physical Reconditioning activities are apportioned throughout this four-week training plan so that the patient recently admitted to the Advanced Reconditioning Section is provided with mild activities of short duration. These activities increase gradually in both intensity and scope, until during the last few days before return to duty the patient finds himself engaged in a rigorous regimen of gruelling activities climaxed by a fifteen-mile march.

The officers and enlisted men charged with the operation of the Reconditioning Program must be basically suited for their duties by reason of experience, leadership, and interest in the program. Because of the highly technical nature of reconditioning, it is imperative that these personnel be detailed at the earliest opportunity to attend appropriate courses in reconditioning now established at the School for Physical Reconditioning Instructors, A.S.F.T.C., Fort Lewis, Washington, and at the School for Personnel Services at Lexington, Virginia. Detailed information pertaining to these courses is furnished in War Department Memorandum No. W350-44, dated July 18, 1944, and in periodic letters to service commands inviting requests for quotas.

The successful execution of the Reconditioning Program requires that the officer charged with its operation be ingenious and resourceful in adapting it to meet the needs of the patients assigned thereto. It must be remembered that improvision is one of the tests of an officer. One of the best convalescent-patient military drills that has been observed in a hospital has been developed at Darnall General Hospital, Danville, Kentucky, where closed- and open-ward neuropsychiatric cases are intermingled.

Evaluation of any new program of this nature is indicative of its success. Annual reports of hospitals for 1944, being reviewed at this date, show in one of our station hospitals 1,435 admissions to the Advanced Reconditioning Program, only twenty-five of whom were readmissions. In contrast to the previous year's experience, when reconditioning was in its infancy, this was a startling improvement. One general hospital reported 3,263 admissions to the Reconditioning Service, and 2,420 dispositions, 983 of whom were discharged to duty, approximately 42 per cent of whom returned to full duty. Changing policies of the War Department concerning physical standards for general and limited service in any one year make such statistical aspects of any annual report of a reconditioning service difficult of evaluation. As basic policies are altered, the reconditioning programs are adjusted and coordinated to either focus on return to duty or return to civil life.

In conclusion, reconditioning in military hospitals provides for planned convalescence. It further reduces the hours of mental and physical idleness on the wards of the hospital by providing a purposeful physical, educational, and occupational program, and in the advanced reconditioning program the intensity of physical and military training is increased so that the soldier patient is discharged to duty, fit to carry out his assignment in his unit in training.

# GENERAL CONSIDERATIONS OF THE PHYSICAL FITNESS PROBLEM

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The Indiana State Medical Association has been interested in "Physical Fitness," as it applies to high school athletics, since 1933. During this time there have been many opportunities to observe the functioning of one of the best-organized programs for physical fitness that existed prior to the war. All boys participating in the Indiana State High School Athletic Association program were examined by a physician as a prerequisite at the beginning of each athletic season.

Sound health is necessary for physical fitness. There is no sense of well-being, and nothing to build upon when disease is present. Conditioning programs are effective only when applied to well people. Corrective efforts are applicable in a minority of instances.

In the hearings before the subcommittee of the Committee on Education and Labor of the United States Senate, certain findings in regard to the number of rejections by the draft boards and military examiners were discussed, and a partial breakdown of the various reasons for rejection were given. Some conclusions were drawn. While this meeting was in progress, Senator Pepper interviewed Major General Lewis B. Hershey, Vice Admiral Ross T. McIntire, Major General George F. Lull, Honorable Paul V. McNutt, and many others.

The Indiana State Medical Association's Committee on Publicity, consisting of Dr. H. G. Hamer, Dr. B. B. Moore, and Dr. K. R. Ruddell sent out a questionnaire to members of the examining boards throughout Indiana. In many counties a tabulation had not been made, and no breakdown in the causes for rejection was available. Dr. Robert Harris, of Noblesville, submitted a list of 162 rejections, including the cause for rejection in each case. In this report there were 82 with inherited defects, such as hemophilia, epilepsy, diabetes, spastic paralysis, blindness, hernia, and nervous disorders. Of these there were 29 mental and nervous disorders, and 7 of these had, at some time, been committed to an institution. It would seem that of these 82 persons only the 20 with hernia could be classed as remediable. Perhaps some of the psychiatric ailments might come in this category. Fourteen were rejected because of a residual ailment, the result of infections. Only 2 were rejected because of venereal disease. It is surprising that there were 11 post-polio cases with deformity. There were 5 goiter problems, and 7 heart and hypertension cases. Sixteen of these 162 were rejected due to the end result of an accident which caused the loss of an extremity or a part of it.

According to the figures given before the Pepper Committee, there are about five million men, between the ages of eighteen and thirty-eight, in the 4-F pool. Two hundred and eighty-six thousand of these are syphilitics, 229 thousand have hernias, and there are a vast number with some neuropsychiatric condition which caused their rejection. It is not possible to arrive at an accurate figure on these neuropsychiatric cases, but 30 per cent of the discharges from the Navy were for neuropsychiatric reasons, and 46 per cent of this 30 per cent were discharged within the first six months. It was also said that 3½ per cent of all naval recruits were screened out because of neuropsychiatric reasons.

If these records of rejections and their causes become available in detail, it should be possible to have a better opinion of how many have a disorder which is correctable in sufficient degree to permit these people to pass military standards. It has been estimated that one out of six are remediable to this extent.

If we take the figures submitted from one county in Indiana, in which only two were rejected because of venereal disease, and compare this with the percentages in other areas, such as the southern states with a high negro population, it would seem difficult to believe that one can draw general conclusions which will be applicable to the different regions in this country. Furthermore, it is well to learn that with the discovery and the availability of penicillin, venereal disease is treated much more effectively and many cures are now possible which were heretofore impossible. For the first time in history it now seems possible to control venereal disease. The tendency to talk about conditions in the country as a whole, and to make plans for a vast program of physical fitness and rehabilitation without taking into consideration the differences in the population and the facilities already available should be guarded against.

One extremely common cause for rejection was loss of teeth. Subsequently the rule was modified and fewer rejections were caused for dental reasons. Undoubtedly, there is need for better dental facilities in some areas, as well as a need for an appreciation of the importance of disease and decay of the teeth.

The point I wish to make is that while some of these disabilities and difficulties, such as dental problems and hernias, are correctable, there always will be a bottom of the barrel made up of mental inadequates, those with inherited diseases, and those who have been maimed by accident.

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No doubt a closer supervision of school children, with corrective measures where necessary, and most of all an intelligent campaign to a better appreciation of physical fitness, will be helpful in screening out the unfit and in preventing nutritional defects. There are differences of opinion as to what is most effective in the development of strong, healthy bodies. Certainly, a boresome routine should be avoided. Calisthenic-minded proponents honestly believe that their method is the better way to develop musculature. It is true that this type of conditioning can be used to good advantage to correct individual frailties, but calisthenics are largely conditioning exercises and do not have associated with them the mental relaxation which goes with play or other competitive sports. Competitive sports also tend to develop responsiveness and resourcefulness. If well organized, they provide a powerful incentive for a youngster to try and try again to excel. In addition, they teach coordination, cooperation, and the ability to produce results under pressure. It has been said that competitive sports help only a few. This concept is definitely wrong because for every boy playing in competition there are dozens and dozens who are trying and practicing in order to become proficient enough to play on the first team. All of these other boys are benefiting in a large degree.

Physical fitness does not mean all things to all people. In everyday life, mental relaxation, preferably with some form of physical activity, is more important than any other thing. This is especially true because in the daily tasks of many human beings the routine is deadly and the pressure is persistent, and staleness is inevitable. Fortunately, many forms of mental and physical relaxation are available, but psychiatrists and doctors dealing with patients in private practice know well the tremendous number of people who are under tension and who are seeking relief from a multiplicity of vague symptoms of purely nervous origin.

There are some individuals who seem not to need any form of physical activity other than that involved in their daily work. Many others go to the extreme of making a fetish of physical activity. If people of these two groups have learned,

## FITNESS THROUGH COMPETITIVE-GAME TRAINING

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"Physical fitness," which has proved to be so essential to the preservation of our democracy, can best be achieved through the development of a competitive-games program. Such training, if it includes all boys, and if begun at an early age, will provide a physical base that will be beneficial to the youth throughout life, and a reserve that can be quickly and effectively utilized for possible military use. It is my belief that no other program, compulsory or otherwise, can provide the essential qualities needed for all-around physical fitness.

I am convinced that only through competitive games can the three-fold development of the body, the mind, and—most important of all—the heart best be accomplished. Neither a fighting heart nor coolness of mind is ever developed through drilling and exercise. It comes only through competition in which the boy learns to react effectively while under pressure. Also acquired through competitive play is team spirit, which is but another word for patriotism.

The competitive-game type of training is not only the most effective, but is also the most attractive type. It should be well organized and supervised with periodic physical examinations. Where corrective measures are recommended, they, too, should be of the competitive type wherever possible. The program can and should be begun as soon as a boy enters grade school. Our entire educational program is based upon the theory that the fundamental principles of a good education must begin at the earliest possible age. Any system of training, to be efficient, extends over a long period of time. A short-cut to physical fitness is no more possible than a short-cut to training in Latin or Mathematics. The time-element in the teaching of strictly academic subjects is no more important than the time-element in developing physical fitness.

Until we have a system that will develop boys with strong bodies, cool heads, and spirited hearts, all of our efforts toward physical fitness will fall short of our goal. The development of a "competitive-games program" is the answer.

each in his own way, how to feel well, and have found zest for living, then that is "physical fitness." The vast majority of people belong in between these groups and find some form of physical effort and relaxation helpful.

How to live; a fundamental knowledge of the rules of good health; the intelligence to accept and to use the facilities available; and to be endowed with sufficient determination to observe the rules—all these are a part of "physical fitness."

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# WHAT IS PHYSICAL FITNESS?

R. L. SENSENICH, M.D.*

SOUTH BEND

"Physical Fitness" may be defined as good health with a minimum of sickness, ability to recover rapidly from fatigue and exhaustion, ability to perform tasks efficiently, and the attainment of a rugged endurance. However, beyond the freedom from disease, physical fitness must be based upon an ideal which will demand that the individual recognize the value of and seek physical fitness as a source of well-being—ability to accomplish and enjoy the fullness of life.

Occasionally physical fitness may come as a result of the accidental combination, in the proper proportion, of exercise and rest, recreation and wholesome habits, upon the basis of a normal mind and healthy body. However, physical fitness implies a certain interaction of mental, emotional, and physical ingredients, and can be attained only as the result of something arising within the individual. The ideal of health and fitness becomes an objective in itself—something to be valued and enjoyed, and therefore to be sought. To some this idea may come as a new value, and to others it at least places a new emphasis upon a priceless possession.

The physical fitness activity includes everyone, begins in the early days of childhood, the first steps in the field of education, and continues throughout old age.

Medicine has long concerned itself with education against disease. Health conferences, public meetings, newspapers and special publications have been directed to the information of the public concerning health matters. The Bureau of Health Education of the American Medical Association has for many years contacted the principal educational associations and other organizations interested in public health. *Hygeia*, the health magazine of the American Medical Association, has as its sole objective to inform the public in matters of health.

Now we have embarked upon a broader activity directed toward assisting the individual to a better understanding of the normal physiological processes of the body, the better maintenance of health of mind and body, and a greater evaluation of those things included in the term "physical fitness" as an objective in itself.

Not only can the average life be prolonged, but the happiness and accomplishments of life can be greatly enhanced. Disease can be more efficiently treated and results very greatly improved when patients are better informed and thus able to cooperate more intelligently with the physician treating them. A better understanding of the importance of the quality of medical service should follow. Matters of health should be considered on the basis of quality rather than economic and political planning.

The present physical fitness activity is based upon the broadest cooperation of the medical profession, government, churches, educational and industrial organizations, and other groups. It is proposed to use every possible means of approach to the public in all walks of life and at all ages. The physician is close to the individual, and much will depend upon him. Every effort will be made to awaken public consciousness concerning the importance of physical fitness for every individual.

The Indiana State Medical Association is to be congratulated upon this Physical Fitness Number of THE JOURNAL.

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* Member of Joint Committee on Physical Fitness, of the American Medical Association and the National Committee on Physical Fitness.

# PHYSICAL FITNESS

J. E. McMEEL, M.D.*

SOUTH BEND

During the past three years the term "physical fitness" has become almost a byword, not only in the medical profession but also among the laity. This, no doubt, has been due, primarily, to the startling revelations brought out by the examining boards for Selective Service, wherein twenty-five per cent of the men examined were found physically defective for military service.

The medical profession has gone a long way in trying to solve this problem. Beginning with prenatal care everything is being offered the expectant mother, not only to safeguard her health but to bring into the world a healthy baby. When a baby is six months of age most health departments contact the family and suggest the beginning of inoculations. At the age of four or five the summer round-up of pre-kindergarten children is made —at least in our community — with physical examinations given to determine defects which can be corrected. In addition, these children are checked by school nurses during their grade years, and when entering high school our community offers a physical examination to all boys and girls before graduation.

This brings us up to the college age; and as medical director of a university that not only believes in physical education but practices it thoroughly, I have been greatly interested in studying the results of a program that requires some type of physical training for practically every student. The defects that we have encountered most in our physical examinations are those commonly found in any group of high school graduates: namely, cardiac lesions, pulmonary lesions, perforated ears, visual defects, hernias, flat feet, allergies, et cetera.

Probably the one type of case that gives us most concern—at least it does to me— is the proper handling of the so-called "cardiac individual." We see young lads in the examining room with every conceivable type of heart murmur, and the amazing fact is that many of these lads tell us that they have been playing football, basketball, et cetera, without any evidence of distress. I think that we can make many mistakes in the handling of these cases. We can either do a boy a grave injustice by permitting him to take part in all types of physical activities without restriction, thus subjecting him to the development of a so-called "athletic heart"; or we can restrict all activities and caution him against any form of exercise, thus producing a cardiac neurosis.

Here is how we try to handle such cases. At the outset we try to determine whether the cardiac lesions are functional or organic. Then we try to set up some form of physical education for our cardiacs. Here is a boy, for example, with a systolic murmer at the apex, or at the base, with no demonstrable enlargement, no sign of congestive failure, and with a pulse rate of seventy-four; after exercise the pulse rate is one hundred and twenty, and two minutes later it is seventy-six. Possibly he does not know that he has a heart murmur, or perhaps he has been told that he has heart disease and that he should refrain from all types of exercise. Now, what should we do in regard to his program in physical education? My personal feeling is that a boy with a cardiac murmur, such as described above, should not engage in either football, basketball, or the distant track events. On the other hand, I do advocate light gym and swimming. These cases, checked later by x-ray, electrocardiography, and clinical examination have shown no evidence of cardiac damage. Cardiacs with slight enlargement and a slow return of normal pulse

## PHYSICAL FITNESS

As viewed by

ED McKEEVER

*Football Coach and Athletic Director*
*University of Notre Dame*

NOTRE DAME, INDIANA

In these years of accelerated academic programs and modified athletic seasons, the physical fitness of competing athletes is more important than it has ever been in the history of intercollegiate athletics. No longer are college coaches able to enjoy long practice sessions with their charges, a goodly portion of which used to be devoted to calisthentics.

Therefore, the Notre Dame coaches have been very gratified to find that high school graduates who come out for sports are usually in top physical shape, and that they are willing to devote their own time and effort to remain that way. In addition, the Navy trainees at Notre Dame are kept in good condition by the rigorous Navy program.

This enables the coaches to spend more time on the mental aspects of the practice sessions, and with proper guidance and instruction keep the young athletes in proper physical condition for inter-collegiate play.

* Medical Director of the University of Notre Dame, Notre Dame, Indiana.

rate after exercise are restricted to exercise derived from walking to and from classes.

In addition to the cardiac cases there are, of course, others among such a large crowd of boys as we have at Notre Dame. In attempting to determine the status of our pulmonary cases, for example, we skin-test all students, x-raying positive reactors for evidence of activity. Pulmonary cases, including healed pulmonary childhood tuberculosis, are admitted to unlimited activity in all branches of physical education.

Perforated drum membranes present a problem which sometimes is very difficult to handle. If the ear shows any sign of periodic drainage I feel that they should be limited to light gym work: if dry since childhood, we exclude only swimming.

Those with visual defects, particularly refractive errors, are given unlimited freedom in their choice of physical activities.

Cases with hernias, if small, are permitted to engage in swimming, only until such a time as correction can be accomplished.

Another condition that confronts us is the large number of so-called "sinusitis cases." Many, and by far too large a number, of young boys have been told that they should not take any type of physical education because of an existing sinus infection. Not being an ear, nose, and throat specialist, perhaps I am not qualified to diagnose sinusitis, but my experience has been that when I could find no dèfinite evidence of infection, our insistence upon some form of physical education has been followed by an improvement in the health of the case in question.

Before the advent of the war we conducted entrance physical examinations on all incoming freshmen. Due to a fifty per cent wartime reduction in our staff since 1942, however, we have requested the students to have a physical examination by their family physician, with the results recorded on a blank furnished by our medical service. Included in the entrance requirements are smallpox and typhoid inoculations, tuberculin skin tests, and x-rays of all positive reactors. If this is not accomplished before the student enters the university, we complete the inoculations.

Aside from the physical-education phase, we have other factors that concern our Physical Fitness Program. One of the main considerations is that of a balanced diet. No group of boys, be they in college, the Army, or Navy, will unqualifiedly and enthusiastically endorse the food they are receiving. To do so would not be the "American way," yet our menus include the basic seven foods that are essential to a balanced diet. In spite of that we have a great number of requests for cafeteria privileges. Such privileges, of course, would permit the student to make his own selection of food, which in the majority of cases, as anyone who knows boys will testify, is wholly inadequate for his bodily needs. Many of our students require special diets, such as the diabetics, cases with duodenal ulcer, and those with definite allergies, nephritis, et cetera. Many such privileges are requested by those who have been permitted to follow a diet of their own liking at home without any regard for bodily needs.

From this rather hastily-sketched summary of some of my observations during the past ten years, I have arrived at some definite conclusions. First, I feel that the real responsibility of attaining physical fitness in our children lies with the parents. Less pampering and catering to whims of eating, and more genuine parental interest in the health of the child would do wonders. Secondly, as doctors, we are as a rule too eager to advise that which our clients wish, and not what our better judgment would dictate. In substantiation of that observation I have received numbers of letters from physicians yearly, requesting that the student be allowed to select his own diet and take only such exercise as he feels able to take.

In closing, I would be remiss in my duty if I did not pay tribute to the excellent work and cooperation of our physical education and athletic departments in carrying out our Physical Fitness Program. Taken as a whole, I do not believe that any university in the country has a higher percentage of physically-fit students than the University of Notre Dame. It has been a privilege and a pleasure to have been able to take part in this program.

## ABSTRACTS

### PHYSICAL FITNESS

"The national point of view in physical fitness," Frank S. Lloyd, Ph.D., New York, says in *Hygeia*, for February, "holds that all of us are responsible. A program on a national level must have as one of its platforms the assumption of responsibility by institutions of all types, and by all our various forms of government. But, above all else, the responsibility of every individual for a personal pride in his own physical fitness must be assumed, too. No worker . . . should ever be absent from his work or be unable to render a 100 per cent contribution day in and day out because he is physically unfit. America is a champion. Great champions must be ready at all times."

### INDUSTRIAL REHABILITATION OF VETERANS

In the absence of an intrinsic medical department, some local Veterans' Administration office must function to evaluate physically and mentally the proper placement of the veteran in industry, and this agency is urgently needed now, J. F. Johnson, M.D., Trenton, N. J., declared in *The Journal of the American Medical Association* for December twenty-third. Dr. Johnson's paper, presented with the cooperation of H. V. Hoffman, of Trenton, is based on personal observations as a physician with one of the divisions of the General Motors Corporation. He also says that the Veterans' Administration should be informing industrial plants as to what to do with a veteran who has either an emergency illness or needs medical or welfare help.

# PHYSICAL FITNESS FROM A PSYCHIATRIC STANDPOINT

E. VERNON HAHN, M.D.

INDIANAPOLIS

Those who are primarily interested in the physical rehabilitation of ex-service men in the postwar period, and of depleted civilians as well, do themselves credit when they recognize an equally important task of mental rehabilitation.

The importance of mental health to the welfare of a society is not always recognized. Daily we hear radio programs and we see multitudes of articles and advertisements in the papers bearing upon improvement in physical status. Eager social leaders and philanthropists devote many hours and great wealth to the encouragement of better nutrition during pregnancy, in childhood, and in adult life. Lawmakers constantly strive to enforce improved health conditions in mines and factories. City planners and welfare workers propose, and accomplish, the clean-up of disease-spreading slums. Reformers strive constantly to remodel our economic structure to provide a better distribution of physical health-producing leisure. And all of this is good.

But is it any wonder that people are prone to fall into the error of believing that sufficient calories, vitamines, and exercise are all that a society needs to be healthy and full of achievement?

And is it any wonder that we all think first and chiefly of *physical* impairments and handicaps when rehabilitation is mentioned?

While there is no doubt that we face a great task in mending the bruised and broken bodies of a society which has been playing too rough a game, we probably face a greater one in repairing the emotional disintegration of many who had to stand greater stresses than they could bear. Medicine today is well prepared to accomplish the first task which will resolve itself chiefly into a question of time, personnel, and facilities. The second task, however, will require a more or less painful educational work upon ourselves. We shall have to extend ourselves a little from the well-known and comfortable terrain of physical medicine into the *terra incognita* of psychological medicine.

There will be a temptation to say "Let George do it." That has been the old formula, supported by the universally-recognized value of specialization. The trouble is that there won't be enough "Georges." Not in a hundred years will there be enough psychiatrists to service all the purely psychiatric patients, even during peacetime, to say nothing of the postwar period. It should, therefore, be obvious that the lesser psychiatric complications of patients requiring chiefly physical rehabilitation will largely be handled by internists, surgeons, and general physicians. The only reasonable approach to this problem, it seems to me, is for physicians generally to reconcile themselves to learning the "hang of it" through consultation with psychiatric colleagues. Thus, upon the relatively few psychiatrists rests a great responsibility of education. It is my belief that this educational influence should be exerted chiefly within the medical profession and not directed toward the lay public for whom a *little* psychiatric knowledge is a particularly dangerous thing.

A brief analysis of the psychiatric situation we shall face may be in order, both to put us on guard and to reassure us. We need to be reassured so as to calm public fears which, if uncontrolled, may tremendously complicate the problem and add to our burden.

In the first place, an enormous number of possible psychiatric casualties have been screened out of the armed forces by Selective Service. In central Indiana this work has been done well by the induction center examiners. I have had the opportunity of re-examining in detail some seventy-five registrants rejected on psychiatric grounds. In no instance did I feel that the brief examination at the center had led to faulty classification. I have no personal knowledge of the possible mistakes in approving for service registrants who

## PHYSICAL FITNESS FOR AMERICAN YOUTH

W. BLAINE PATTON

*Sports Editor, The Indianapolis Star*

INDIANAPOLIS

I am a strong believer in any physical fitness program for American youth as a postwar program, which will not only encourage them to use their muscles but will develop their powers to think quickly in a pinch. There are plenty of American games for all ages which fit the bill perfectly. Physical culture, as they call it in Germany, with the idea of mass production of strength only, and the weeding out of individual competition, decidedly is the wrong slant.

Personally, I believe that gymnasium classes, setting-up exercises and the like have their proper place, but it is the game—the actual playing of the contest and the desire to win by fair means—that really pays off in big dividends. Our present war has demonstrated this on many a battlefield. Physical fitness dovetails directly in that respect as a companion part.

should have been excluded, but it seems probable that very few poor risks were passed, judging from the high degree of insight displayed by the examiners, as shown by those rejected and referred to me for consultation.

The fact that there have been many psychiatric casualties among servicemen discharged for medical reasons should not be interpreted as a reflection upon the judgment of the induction center examiners. The science of psychiatry probably will never provide criteria exact enough to distinguish between persons who certainly will never develop mental disorder and those who certainly will. Life is too full of unwonted circumstances for that. Minds are susceptible to stresses just as bodies are susceptible to bullets. But I should hasten to add that the mind is less vulnerable than the body, and that it often heals more quickly.

Many of the acute mental cases in the armed forces are now understood as transitory cases of "fatigue neurosis" or "combat neurosis." Army and Navy psychiatrists have developed techniques of treatment so effective that many of these men can be returned to limited duty. We likely shall see fewer deteriorated cases of "shell shock" than those that followed the previous World War.

The severe psychoses among ex-service men requiring institutionalization will, of course, be handled by the government. But many of these will eventually be returned to civil life with a recovery of a sort. These will be added to a considerable number of mentally unstable persons who for one reason or the other will not be treated under government auspices, but who will come under the care of private physicians. It is with respect to all these that we need to be especially on guard so that our medical and surgical measures may not actually aggravate a latent psychoneurosis or psychosis. It is with respect to this group that the surgeon needs to develop a better "olfactory sense" for mental disorder.

For the early detection of emotionally unstable patients this one suggestion may be dropped. When the symptoms are not immediately explained by obvious physical abnormalities, and especially when the symptoms do not fall into patterns characteristic of known pathologic entities, it is wise to call for psychiatric consultation, no matter how "normal" the patient's personality may appear to be. To proceed with usually harmless physical treatments, such as plaster casts for painful backs, minor rectal operations for trivial lesions, prolonged intra-nasal treatment for minimal sinus involvements, and so forth, may actually increase the anxiety of the patient and precipitate an acute exacerbation in a chronic mental disorder.

After this brief consideration of the groups of ex-service men whose rehabilitation may require psychiatric consideration, let us turn for a moment to the problem of the morale of the stay-at-home civilian population. They should be taught not to view the mental state of the returning servicemen with anxiety. Probably too much sensational publicity has already created a sense of apprehension which will not make the returnees any more comfortable, and which may contribute to severe reactions. The public should be reminded of the remarkable stability of the mind and of its strong tendency to reintegrate itself even after severe strain.

With confidence in our own determination to use our heads, to deliberate before launching into treatment, and to employ the facilities at our command, let us promote calmness and good sense among laymen.

## SEA EVACUATION

Responsibility for the evacuation of sick and wounded in overseas theatres and their concentration at ports at which they will be embarked upon ships destined for the United States rests with the theatre commander concerned. Upon the embarkation of such patients at the overseas port, and the departure of the ship from that port enroute direct to the United States, command responsibility is assumed by the Chief of Transportation for and in the name of the Commanding General, A. S. F. Upon the debarkation of the patients at the port of entry in the United States, they are turned over to the Commanding General of the Service Command concerned, who then assumes responsibility for them. Responsibility for medical technical supervision rests with The Surgeon General throughout.

The facilities aboard the ships are such that those patients who need considerable hospital care enroute can receive such care, to include not only routine dressings and medical care, but also emergency surgery and other treatment where indicated. In addition, a hospital ship can be used for the immediate support of an amphibious operation, providing floating hospital facilities to insure the availability of means necessary for immediate treatment of the sick and wounded arising from such an operation.

It will be noted that an apparently large proportion of the facilities aboard the hospital ship are suitable for the care of mental patients requiring restraint during evacuation. These facilities are provided in these apparently large proportions because the opportunities for self-harm are naturally greater aboard a ship at sea than on land.

When the ship leaves the theatre the War Department and the port of destination are notified as to the number and general types of patients aboard, and immediate steps are then initiated to provide for their reception in this country. Suitable plans are made by The Transportation Corps, which operates the port; the Commanding General of the port notifies the general hospital nearby serving as a debarkation hospital, and also the Service Command within the geographical limits of which the port is located, of the number of patients enroute, their types, and the approximate time of arrival. The same information is forwarded to the Chief of Transportation and The Surgeon General in Washington, and other interested War Department agencies. At the debarkation hospital each patient is classified in accordance with his home address, and in accordance with any special treatment facilities required, with a view to moving him as expeditiously as possible to that general hospital having the needed treatment facilities, and located nearest his home. Then, by a coordinated effort between the local hospital commander, The Surgeon General, the Chief of Transportation, and the headquarters of the Service Command concerned, the patients are moved by rail, air, or bus to the selected general hospital.

# SOME PRACTICAL CONSIDERATIONS OF CARDIOVASCULAR EXAMINATIONS IN YOUTH

ARTHUR B. RICHTER, M.D.

INDIANAPOLIS

The majority of people under twenty-five years of age have healthy cardiovascular systems. The total incidence of heart disease in high school and college youths in Indiana is probably in the vicinity of 2 per cent, and less among those boys who qualify for athletic teams. However, the examining physician should not depend upon the infrequency of cardiovascular disease among youths with athletic skill. Individual examinations should be conscientiously and thoroughly done.

The family doctor too often depends on the medical background and permits strenuous physical effort after a hurried and incomplete examination. Then, too, the boys on the school team may deliberately choose a doctor who does examinations in this manner in order to save time and insure medical certification. Coaches, in their desire to have a winning team, have been known to send a player disqualified by one physician to another, who, lacking pertinent information, passed him. I well remember a boy with active rheumatic fever and cardiac involvement whose coach was advised that he could not continue to play basketball. The next season, with the approval of another physician, he again played as a varsity regular and continued until graduation. Not many years ago a team lost in the semifinals of the state basketball tournament, at Indianapolis—three of their regulars playing had measles. When the desire to win has such a grip on parents, as well as coaches and high-school principals, one can understand some of the problems the family or team physician faces.

In order to place more responsibility on the physician and officials of the school, I recommend that one or more physicians in a community be given the duty of examining the children. These doctors should have enough time to do thorough examinations and should receive adequate compensation for their work. When a cardiovascular defect is found or suspected, the youth's parents should be informed. If there is the least doubt concerning the nature of these findings, examination by a qualified cardiologist should be arranged for by the family physician. The number requiring consultation would not be great. Nonetheless, the family physician should no more assume the complete responsibility for making a decision that, if in error, may induce cardiac neurosis than for performing a major operation if he is not trained in surgery. Once a neurosis is established it becomes the problem of the cardiologist. He must tell the patient the original diagnosis was wrong. It is not enough to say the examination was incomplete. The physician who with inadequate facts makes an erroneous decision may create a cardiac neurosis, which may never be completely relieved, even by several heart specialists. We are all learning that despite constant improvements in the methods of study provided by the fluoroscope, x-ray films, the electrocardiogram, the ballistocardiogram, et cetera, the range between the definitely normal heart and the abnormal one is often so wide that one cannot always draw a sharp line between the two. Furthermore, we must remember that the heart has remarkable powers of adjustment and reserve. Therefore, statements that may well create an anxiety state, even though organic heart disease be present, must be made advisedly.

A systolic murmur, a rapid heart, extrasystoles, slightly elevated blood pressure, hypotension, possible cardiac enlargement, and the question of active rheumatic fever constitute the common cardiovascular problems among people under thirty.

The examiner must be able to distinguish a diastolic from a systolic murmur. In the absence of severe anemia a definite diastolic murmur always indicates organic heart disease, which usually is rheumatic in origin, but may be congenital, and which rarely is syphilitic. I have seen syphilitic aortic insufficiency in a girl eighteen years of age.

Systolic murmurs over the precordium, usually maximal in intensity at the apical or pulmonic area, are common. If produced only by exercise, a systolic murmur should be disregarded. However, if exercise reveals a presystolic murmur or a mid-diastolic rumble, mitral stenosis is probably present. The patient should be examined in a sitting, lying, or in the left lateral position. Regular performance of all of these, and especially the latter, should detect most cases of mitral stenosis. Levine suggested that systolic murmurs be graded on the basis of one to six, depending on intensity of sound. Murmurs of grade three or more are nearly always accompanied by other evidences of organic heart disease, such as a diastolic murmur, thrill, cardiac enlargement, and electrocardiographic abnormalities. A grade two murmur may indicate no organic heart disease. One can be clinically certain of this in the absence of a diastolic murmur, thrill, or rheumatic history, and x-ray evidence of no cardiac or pulmonary artery enlargement. Most of these patients will show only a grade two murmur during many years of observation. A few, however, will develop evidence of mitral stenosis. If the murmur is of grade one intensity, and no other evidence of heart disease is present, it should be disregarded. When a grade one or two murmur is the only finding in young people, their physical activity should not be limited in any manner. Terms such as "leakage of the heart" or "leaking

valve" should never be used to describe a murmur to the patient or the family.

Cardiac rates of below 60 or above 110 per minute, without signs of disease, account for many cardiac neurotics or unnecessary limitation of physical activity. This is also true of extrasystoles. There is a wide range of normal pulse rate influenced by many factors. Athletic training tends to produce a slow pulse. Anxiety about one's heart tends to cause a rapid rate. This is typically seen in neurocirculatory asthenia.

After infancy an examination should include the blood pressure and palpation of the femoral and posterior tibial artery pulsations. If hypertension is present or these arterial pulsations are diminished, the blood pressure should be taken in the lower extremity. Normally, it is higher than in the arm. In coarctation of the aorta the blood pressure is lower in the leg. This congenital condition may account for an occasional case of hypertension. Coarctation should be ruled out in nearly all instances of congenital heart disease.

Essential hypertension frequently makes its first appearance in young people, and will be manifested in its early stages only by rises in blood pressure above accepted levels. This will occur after exercise, excitement, et cetera. Peak elevations above 160 systolic and 95 diastolic should be checked periodically without making the patient blood-pressure conscious. If the diagnosis of essential hypertension is established, competitive athletics should be eliminated.

When in the presence of hypertension the examination of the urine shows albumin and/or red cells, glomerular nephritis may exist. After every cold or sore throat in young people a urinalysis should be done. At that time the physician should be alert to such findings as headache, bloody urine, oliguria, edema of the face, hypertension, et cetera, all of which are indicative of acute glomerular nephritis.

Hypotension is not a disease and should not be used to explain fatigue and numerous other complaints. It might aid in the diagnosis of Addison's disease, and may be a definite syndrome as in postural hypotension and orthostatic tachycardia; otherwise, hypotension should be disregarded and not mentioned to the patient.

In my opinion, the determination of cardiac enlargement from physical examination alone is justifiable only when the point of maximum impulse is well to the left of the mid-clavicular line and other evidences of organic heart disease are clear cut. It is a serious matter to tell a patient that his heart is enlarged. It is difficult to detect borderline cardiac enlargement even with complete x-ray studies, including fluoroscopic examination with barium in the esophagus. However, an occasional case of mitral stenosis or congenital heart disease will be discovered by x-ray in the absence of diagnostic murmurs. Hypertensive heart disease, myxedema heart, and pericardial effusion are often found by x-ray alone. For these reasons it would seem wise that the members of the athletic teams in our high schools and colleges should have an x-ray of the chest each year. Here again one must warn against the danger of reading cardiac enlargement into a film when it does not actually exist. Incidentally, a few cases of early pulmonary tuberculosis may be discovered even in these "healthy" people.

The so-called "athletic heart" will not be discussed except to state that physical strain has been thought rarely to cause the normal heart to enlarge in rapidly-growing adolescents; however, this question has not been definitely settled. The important point is recognition of the diseased heart and sparing it from excessive physical activity. Not uncommonly a successful athlete with undiagnosed mitral disease, rheumatic aortic insufficiency, or a combination of these two lesions, will be found. No doubt, sudden death of a boy during an athletic contest is usually due to an unrecognized organic cardiovascular lesion.

In Indiana approximately one-third of those children of high-school age with organic heart disease will have rheumatic heart disease. There will be a considerable group suspected of having organic heart disease. Actually, some of these will be normal, some rheumatic, and others true congenital heart disease. Subacute bacterial endocarditis, hypertension, glomerular nephritis, and active rheumatic fever will account for most of the remainder.

We must be alert to the possibility of active rheumatic infection. When present, or strongly suggested, the patient should be put at bed rest and receive large doses of salicylates until all clinical signs of activity have disappeared and the sedimentation rate is normal. The electrocardiogram may be of benefit. In the United States rheumatic heart disease and rheumatic fever are responsible for more deaths in the five- to fifteen-year age group than any other infectious disease of childhood, while in the ages fifteen to twenty-four years it is second only to tuberculosis.

The electrocardiogram is of greatest value in coronary artery and hypertensive heart disease. Among young people it may aid in diagnosing rheumatic fever, myocardial changes in other acute infections, pericarditis, congenital heart disease, and the arrhythmias. The physician must be able to apply the electrocardiographic findings to his patient, and should never use them as an isolated cardiac diagnosis. Many who use the electrocardiograph lack skill in electrocardiographic interpretation. Those who use this instrument should be willing to take postgraduate training in cardiovascular diseases for at least a month, followed by a two-week course in electrocardiographic interpretation. A physician with this training will be responsible for few cases of cardiac neurosis.

In conclusion, my desire has been to stimulate more accurate diagnosis of cardiovascular defects among young people by emphasizing the great danger of producing cardiac neurotics. The national program for physical fitness has an excellent pur-

pose. Examination of our youth on a large scale is desirable. Whenever cardiovascular defects are discovered or suspected, an attempt should be made to diagnose them accurately and completely with the aim of securing adequate treatment and protection of the heart when diseased. During the process of such examinations the individual becomes "heart conscious." If the conclusions are in error or if he is not properly managed by the physician and parents, an anxiety neurosis develops which may become more of a handicap than organic heart disease.

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## HOW A HEALTH PROGRAM CAN GO WRONG

The following article by Joe Williams, one of America's best-known sports writers, emphasizes very expertly the fallacies involved in some of the proposals for a vast and haphazard Physical Fitness Program. In fact, some of the statements which have been made are definitely due to a lack of understanding of what can be accomplished in the reclamation of the physically unfit, or have been made with motives which have little to do with the Physical Fitness Program.

Military standards will always require perfect specimens, at least specimens without blemish, and nature just does not grow them all that way. Everyone will be wholeheartedly in favor of a program which will reduce the number of unfit, but it will take some hard-headed thinking and restraint to avoid a vast, nonsensical, money-wasting scheme.

(This article by Joe Williams, Scripps-Howard sports columnist, appeared in the *Indianapolis Times* of February twelfth.)

"Don't look now, but isn't that Herr Health-Through-Joy which has just made its appearance in congress in the form of a peacetime physical training bill, sponsored by those two old footballers, Sammy Weiss and Freddie Hartley? Looks mighty like it from the sidelines.

"Everything about the bill has a familiar ring. First there is to be a supercommittee working out of Washington. Then there are to be subcommittees functioning in each state. The objective is to make all the little kiddies and their big brothers and sisters happy and strong . . . 'through physical training, competition in sports, camping, hiking and kindred activities.' Of course, all this can't be done with milkbottle tops. A little money is needed. The old footballers think twenty-five million annually as a starter might serve.

"Interviewed by the United Press, Representative Weiss, of Pennsylvania, cranked up his forward-passing arm and let fly with a mess of dismal statistics calculated to show that one of every five draftees had to be rejected because of physical defects.

" 'If this program had been in force before the war,' he added, 'it would have saved countless thousands of lives, made it unnecessary to draft married men, eliminated the consequent impact on American families, and averted the current manpower crisis.'

"Well, certainly there is no argument against health or a program which adds to health. But before we go overboard on the Weiss-Hartley program, let's explore the situation a little closer. Now only a small percentage of men were rejected because of chronic ill health or physical debility. What kind of training program would you recommend for missing eyes, twisted limbs, bad tickers, and mental disorders? Thousands and thousands of the rejectees fell into this assorted category.

"And how about the other 4-Fers, punctured ear drums, flat feet, deafness, ulcers, et cetera? These are the fellows who are playing major league ball and professional football, much to the bewilderment of War Mobilizer Jimmy Byrnes and others. The Army says it doesn't want these men. Would the Weiss-Hartley program change all this?

"What is happening here is that Weiss and Hartley have picked up the pet baby of the professional physical cultists of this country who, for the past ten years, have been trying to regiment the training of the American youth. It is such an easy bill of goods to sell, because it is tied with such pretty ribbons. Healthier children, healthier Americans.

"To hear these gentlemen talk you would think the subject of physical training was completely unknown to America. You would think that they discovered it over night. The fact is, of course, that every state has a physical program which is supplemented by numerous agencies such as Y.M.H.A.'s, Y.M.C.A.'s, C.Y.O.'s, intercollegiate athletic associations, and welfare organizations. Let's admit, for the sake of discussion, that the state programs and corresponding agencies are not without flaws. If this is so, why not move to improve and expand them? Why federal control? Why more and more commissions, and bigger and bigger appropriations?

"The very great danger here does not meet the casual eye. This lies in the hope of a pseudo-educational group, through political assistance, to take over direction of the American youth at a tender age. The Weiss-Hartley Bill, for example, calls for the start to be made in kindergarten, and while the authors of the bill disclaim any attempt at regimentation, they are proceeding, nevertheless, along just such lines, whether they realize it or not.

"You'd be surprised to know how many unrelated items these professional physical cultists seek to squeeze into what on the surface appears to be simply a program to build strong healthy bodies. These include everything from tap dancing to stenography—no fooling!

"The Weiss-Hartley Bill should be defeated. No matter how thin you slice it, it is still Health-Through-Joy stuff. And just as bad, if not worse, it's a move to build up another powerful power bloc—and God knows we've got enough of those as it is. Right, Sidney?"

*THE JOURNAL*

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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MARCH, 1945

# Editorials

## TWENTIETH ANNUAL SECRETARIES' CONFERENCE

The 1945 edition of the Secretaries' Conference, like many of the ones which preceded it, was conducted smoothly and efficiently by Dr. A. M. Mitchell.

This year's session, while not as elaborate nor as well attended as last year's session, was conducted along the theme of the effect of the war, and its emergency situations, on the medical profession. This included the potential threats to the continued independence of the profession from governmental interference.

"The Bolton Law and Its Relationship to the Patient" was the title of the paper discussed by Jane E. Taylor, nurse education consultant, Division of Nurse Education, United States Public Health Service, Chicago.

Mr. Don C. Hawkins, special agent, American Health Insurance Corporation, Chicago, gave a brief outline of "Group Malpractice Insurance," as set up for the members of the Indiana State Medical Association, and a brief discussion of the problems involved in health and sickness insurance.

"The Children's Bureau Program" was presented by Dr. John D. Van Nuys, Medical Director, Indiana University Medical Center, Indianapolis. Doctor Van Nuys brought out the attitude of the directors of the medical center toward a recent directive of the Children's Bureau. In this directive the parent or guardian of a child would be able to take any child to the medical center for diagnosis without being referred by a physician or by any welfare agency. It was felt that inasmuch as the Children's Bureau contributes only about thirty thousand dollars toward the entire cost of the hospital program, it should not be permitted to dictate the policies of the hospital. Therefore, after July 1, 1945, the hospital is dropping out from participation in the bureau program. The hospital will continue to take care of children of the State of Indiana in the usual manner.

Charles Fidler, M.D., President, State Medical Society of Wisconsin, Milwaukee, discussed a junket made by a committee from the Wisconsin State Medical Society to Washington and New York. There they interviewed many notables, including Senator Wagner; Mayor LaGuardia; Miss Lenroot of the Children's Bureau, of The Department of Labor; The Surgeon General of The United States Public Health Service, and others. The attitude of most of these individuals, The Surgeon General of The Public Health Service excepted, was that of telling the medical profession what they were planning on doing, rather than asking for advice and cooperation of the profession in working out problems of public health and care of the sick.

Dr. O. E. Wilson, of Elkhart, gave a paper summarizing the answers to a questionnaire concerning the activities of the county medical societies of the State of Indiana. Emphasis in the conclusion was placed upon a plea for unified action in problems medical, and a strong public relations effort on the part of county societies.

The discussion presented by Lieutenant Colonel Harold Lueth, Liaison Officer, Army Service Forces, Surgeon General and the American Medical Association, Chicago, had to do with the results of a survey conducted among the medical officers in the Army, concerning the type of postgraduate training desired by the returning medical officer. Plans are now being formulated to set up the proper educational facilities to take care of this educational program.

Following an open forum and some questions, the conference re-elected Doctor Mitchell as secretary for the ensuing year. Dinner was served in another part of the Riley Room of the Claypool Hotel. During the dinner Governor Gates, of Indiana, addressed a few remarks of welcome, and pledged his good wishes to the medical profession of Indiana.

Dr. N. K. Forster, President of the Indiana State Medical Association, was introduced by Chairman Mitchell. Dr. Forster gave out with a group of good stories, and becoming serious in his closing remarks asked for the united support of the profession in Indiana during this coming year in meeting the problems confronting us. He then introduced the principal speaker of the evening, Congressman Arthur L. Miller, of Nebraska.

"Uncle Sam Practices Medicine" was the title of the paper presented by Congressman Miller, who cited from the Interim Report of the Wartime Health and Education Committee of The United States Senate the section concerning the number of Selective Service rejections because of physical and mental defects. Congressman Miller, who is a physician, warned that the medical profession is getting too many plans, and had better settle on something definite—and soon—if we wish to prevent federal control of the profession. The Congressman himself has presented a bill in the House for a secretary of public health, to correlate all present health activities of the Federal Government, this secretary to be a physician and to be of cabinet rank. The profession will do well to keep its powder dry.

Those who missed this meeting really missed something worth while.

## IRVING S. CUTTER

Again does American Medicine record the passing of one of its most ardent devotees, a man of unusual and seemingly unlimited capabilities, all of which he used to their greatest extent. Only a few years ago, while in the Passavant Memorial Hospital, as an "observation" patient where Doctor Cutter was serving as general superintendent, we asked him just how many major jobs he was holding at that time. Among them he enumerated his post at the hospital, dean of Northwestern University Medical School, health editor of the *Chicago Tribune*, and medical director of the Northwestern Railway Company.

We asked Doctor Cutter how he managed to find the time to carry on all this work, and his reply was one word, "ORGANIZATION." And he has done just that—each job was thoroughly organized. He had the most capable assistants, plus an energy of the indefatigable type.

As dean of the medical school he brought this institution to the very top; its standing is of the highest, and that alone could be memorial enough for one man. But across the street, at the Passavant Hospital, he had another task, and at once he set about to get that in order, which he did in a short time.

His railroad work required much attention, but by thorough organization he managed to get that done also.

If any of his work was more outstanding than any other, we should say that his health column in the *Chicago Tribune* took the palm. Here he talked daily to hundreds of thousands of regular readers. We do not hesitate to aver that this column had the largest audience of any similar column in the country. Many have said that they depended on this column to keep them posted on matters pertaining to health. To some it was a fetish; they would no more think of starting the day's task without reading that column than of going without breakfast. As a member of our family put it, "Doctor Cutter was *my* doctor—just as Harry Emerson Fosdick is *my* preacher—and I do not personally know either of them!"

He possessed a keen sense of humor, which was liberally sprinkled among his answers to letters received from his readers. He did not use redundant phraseology; his sentences were of the cryptic sort, and much to the point.

As would be expected, Doctor Cutter was an avowed enemy of socialized medicine. He had spent years of his medical career in work of such a nature as to enable him to see, as few of us have seen, the evils that would follow any interruption of medical progress. In later years he had been in demand as a speaker on medical topics before audiences in every section of the country, and on each occasion he embraced the opportunity of making it clear that any infringements placed on medicine would be suicide.

With the passing of Doctor Cutter, we have lost one of our greatest assets in medicine; he was a real leader, a man of the type that is all too rare today. But he built himself a monument, a monument that will endure for years to come.

## CARING FOR THE MENTALLY ILL

According to newspaper reports, Indiana is approaching this problem, which of late has become very acute, with much understanding. The mere erection of state hospitals, even though they be competently manned, is not enough; the problem is a much deeper one. It now is proposed to bring about the formation of a Council for Medical Health, and to erect a special set of buildings for the housing of this council; these buildings to be erected on the campus of the Indiana University Medical Center, and the hospital to be operated under the direction of the medical school.

It is proposed that for the most part this institution be operated on the same plan as are the private sanitaria, and that it serve as a training school for physicians who wish to take up psychiatry as a specialty.

Patients would be received from other state hospitals when it is adjudged that special treatment is advisable; they would also be referred by our county courts. An individual citizen would also have the privilege of seeking admission thereto.

At the present time there are more than thirteen thousand patients in our state hospitals, which means that these are grossly overcrowded—overcrowded to such an extent that many patients have to be denied special, personal treatment.

Again, according to newspaper statements, the cost of treating a mentally ill patient, under our present system and providing he remains there throughout his adult life, is estimated to be something like eighteen thousand dollars. We do not have at hand the report showing the maintenance

cost of our five state hospitals, but it is a sizeable sum.

There is no denying that mental illness is on the increase, chiefly due to war conditions; and there is every reason to believe that this increase will be greatly magnified as time goes on. Every physician in active practice knows this to be true; on every hand he sees signs of such portent.

Society owes these unfortunates the best of care and the use of every resource to restore them to a useful life. Psychopathic cases occurring in our armed forces will be cared for in government-owned hospitals, for the most part. This is as it should be, but we have the additional obligation of caring for such civilians as may need this special care.

The plan as proposed may be somewhat visionary, but it indicates that our folk are thinking along these lines. The proposal for the erection of a sixth state hospital would, if carried out, be of much assistance in the solution of this problem, but the proposal for a special institution has much merit and should have the careful consideration of the Indiana medical profession.

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## OUR STATE IN PHYSICAL FITNESS

Yes, we were shocked to learn that so many of our young people were unfit for military service, and we agree that something should be done about it. First, however, before deciding to do something, we must decide *what* to do. It will not help much just to do *something—anything*. What is the nature of the unfitness? Is it something that can be corrected? Is it something that we physicians should correct, or is it possibly something that can be done by the whole population? There is a tendency to look toward the medical profession as if it had been remiss, in spite of the fact that we are whipping the transmissible diseases consistently; that we are saving surgical and medical cases which would have been hopeless a few years ago; and that we are, with the help of other forces, rapidly prolonging the average length of life. What are the principal causes of rejection, and just what can be done about them?

Well, there are first those who are *mentally* unfit—the dumb, the deranged, and the illiterate. Frankly, we do not see how the physicians could have done much about that in times past. Some of us have insisted for decades that nitwits should not be allowed to marry and beget a houseful of feeble-minded children, but nothing has been done about it. Some have urged that wives in such families should have instruction in birth control, but little progress has been made. Possibly some of us have wondered if a newborn babe which is clearly defective should be saved, but it is our duty to try to save it.

We believe that a careful study and sorting of persons who are beginning to deviate mentally might result in the salvage of a considerable number of them, but funds for such a clinic have not been made available, although at the present writing it looks as if such a beginning might be made by the legislature. Illiteracy is hardly something that we would be expected to correct, and much of it is due to immigration from states with inferior school systems.

*Dental* deterioration is an exceedingly important cause of defect and rejection, and is our responsibility in a small way. However, great progress has been made in recent years in understanding the cause of dental decay. We may look to marked progress in this field if the population will make use of the improved knowledge which the dentist and the physician can supply, but there is little that can be done if the people continue to disregard professional advice in such matters.

Many of our young people are said to be suffering from one or another phase of malnutrition. Yet they are growing taller and larger than ever before; they are breaking athletic records constantly; and they are making wonderful soldiers, sailors, and marines.

Enormous emphasis has been placed upon nutrition in recent years. As a matter of fact, we have said so much about it that we may have overdone it somewhat, thereby tending to cause a revulsion of feeling. It is hard to see how we could have done more in the way of teaching, for after all we can not go into the home and compel people to eat as they should.

Oh, yes, there are plenty of medical and surgical causes of rejection. For instance, here is a man with a punctured ear drum due to neglect years earlier. Medical neglect? The answer is that in most such cases the physician was not seen until the drum had ruptured, or was well along toward that end. There are rheumatic hearts, tuberculous spines, and arthritic joints aplenty, but we should like to ask those who hold us responsible just what could have been done about them. The time may come when we shall know how to prevent such things, but it is only partly here now, and, of course, there is a lag of about two or three decades before such knowledge can come into expression in the lives of young men of military age.

We can put glasses on a chap who has bad eyes, but for the most part there is nothing else that can be done for color-blindness, shortsightedness, farsightedness, or astigmatism, unless one believes that diet and eye exercises can correct such defects. We might further illustrate such cases: Bill Jones shot his foot off, and it was amputated below the knee by a surgeon; John Doe, as a lad, was hit in the eye with a dart, and the eye had to be enucleated. Until surgeons can do miracles there is not much that can be done to keep Bill and John in the accepted list.

The medical profession could have done better, of course, and everyone else could have done better, but it didn't seem necessary that every boy should become a soldier. It seemed as if a lot of

people could be useful and happy even though they were not physically perfect. It seemed as if we would need brains as well as brawn if we should ever actually go to war, and such has been found to be the case. There are many places in the Army for men with physical limitations. There are other desirable things besides straight backs and big muscles. It is entirely possible that in a total war the little myope might make a far bigger contribution with his scientific book-worm stuff than the gymnast who would win the war with his bare hands.

The first thing in physical fitness is *general health*. Let's keep right on trying to keep our young people well and vigorous. This end is not attained merely by physical exercises; it is an *ensemble* with the physician, the dentist, and the nurse showing the way. Let's keep hammering away at the nutrition angle. Let's build gymnasiums for *all* of the children—boys and girls—rather than for the varsity alone. Let's have more and better playgrounds, swimming pools, boy and girl scout troops, more schoolhouses open the year around—for recreation in the summer, and for community service twelve months in the year. Let's get the churches lighted up for the *young* people on week nights. Let's keep on immunizing everybody in sight against the diseases which weaken hearts and kidneys. If we need more hospitals, let's build them where needed, being very careful not to build them where *not* needed. Let's keep *feeding* the goose (the medical profession) which laid such a beautiful golden egg (our modern facilities—medical, surgical, and health) so she will keep on laying more and more of these golden eggs. Let's not kill the goose so as to get all the eggs at once.

General physical fitness is a very desirable thing to have. It is a splendid ideal toward which to work. It will not be accomplished over night. We shall not gain it by dropping our time-tried methods, which have brought us far, and dashing after a will-of-the-wisp which promises to bring us to it immediately. Let's keep up the good work, with physicians, dentists, nurses, teachers, preachers, coaches, parents, scoutmasters, Y.M. and Y.W.C.A., park boards, and everyone else right in there pitching. We must work together on this thing; we must avoid blaming each other; and we must keep right on doing even better the things we have been doing rather well.

Complete report
of legislative session
will be carried in
the April issue
of THE JOURNAL

# Editorial Notes

The state press seems to have been favorably impressed with the proposal to make some changes in the Medical Practice Act, changes made necessary by the radical change that has taken place in medical teaching, resulting in the closing of several sectarian schools, such as the eclectic and the physiomedical.

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Another thing we may expect from the new state officials is more activity in the control of stream pollution. Governor Gates apparently is well aware of the manner in which our state waters have been polluted over the years, and seems determined to do something about it.

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The Council on Foods and Nutrition, of the American Medical Association, definitely does not approve of the addition of synthetic vitamins to candies, according to a recent bulletin from that body. This pleases us very much, for if prewar candy were available it would be plenty good enough for us, as is or was.

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Senator Pepper is quoted as saying, "I've been trying to find a way of avoiding compulsion. I've been trying to find a cooperative method of solving our medical problems." Land Sakes! That's just what the medical profession wants; just what they have been trying to do through all these years—cooperate with anyone who wishes to be fair about things!

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In January a complete hospital survey, conducted by a group of nationally-known hospital consultants, was made in Evansville. It covered all health matters, professional service available, and a complete analysis of the hospital facilities of that city. We shall look forward with much interest to that report, since it is only by such intensive study that we may know just what the conditions are, and what the remedy should be.

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THE JOURNAL is deeply obligated to all who have contributed to the special Physical Fitness Number, a subject now very much before the American people. We appreciate the assistance of those who have contributed articles, and wish to extend a special vote of appreciation to Doctor Wendell D. Little, of Indianapolis, who has served as a general "clearing house" in getting this material together. In addition to the great amount of time he devoted to the project, Doctor Little prepared one of the articles. Again does THE JOURNAL thank him for his efforts.

The study of penicillin goes on apace, and each month the medical literature teems with announcements of new uses for this valuable addition to our remedies. However, we caution the average general practitioner against doing personal experimentation with this agent. Our observation is that it is much better to follow the research reports issued by groups that have every facility to observe the action of new material.

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There is much potential danger in the proposal that federal grants be made, right here in many Indiana cities and towns, for the purpose of erecting hospitals. Who could tell just how long it would be before official Washington would step in and take over the control of such institutions? And that, in our opinion, is just what would take place. There are plenty of ill-advised officials down in Washington who are set on taking over the medical profession, and the plan as above proposed would be right down their alley. While it is true that we do need a few more hospitals about the state, there is no reason why these could not be built by local counties.

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Every physician now in active practice should be interested in the Physical Fitness Program that is being launched by the medical profession. We all are responsible for the success of this campaign. We know of its great need; we know how to overcome the defects that the war has made so clear, and which affect such a large percentage of our young men—the thing to do now is to take every possible step to remedy the matter. One way in which great help may be given the project is by studying lost-time cases in industry. Every employee who frequently is absent from his work should be very carefully checked, and, if possible, the causes for his frequent defection should be removed.

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"To be or not to be." That remains the question as to whether we will hold our annual meeting, come next October. At the present writing all conventions attended by more than fifty members are "out," and the prospects for a reversal of this order in the near future are very slight. Transportation conditions are not improving, and, in our opinion, will grow much worse. Railroad executives tell us that the public "does not know half the story," and that civilian travel is well on the way out for the time being. Nor do we look for any improvement in the gas-rationing program, probably not during the present year. The Pacific war probably will continue for a long time to come, and gasoline will be needed there in much larger quantities than at present. Plans should be made to enable a one-day meeting of the House of Delegates, sometime this fall, as many matters of importance must be decided; it is probable that a "permit" could be obtained for such a purpose.

While rat bite fever is not a common malady, physicians will be interested in the report of three Cincinnati physicians, *The Journal of the American Medical Association*, February 3, of three such cases successfully treated with penicillin. They state that but seventeen such cases had been reported in the United States.

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We would like to make a suggestion that after the end of the war a list of men over the age of seventy, who have maintained their medical practice, be given an honored place in the archives of the Indiana State Medical Association. And while on this subject, it is well to remind the "home guard" group to "take good care of themselves"; the death rate among physicians is presently higher than ever before; this, of course, being due to the additional burdens put upon them.

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Governor Gates, in his thirteen-point health service program, makes it clear that he is favorable to a sane, common-sense health program. Among the matters mentioned is the reorganization of the Indiana State Board of Health, making it a seven-man board, consisting of three physicians, one dentist, one sanitary engineer, one pharmacist, and one woman who has demonstrated that she is interested in public health. The terms would be for four years, so staggered as to assure a majority of seasoned members in service at all times. THE JOURNAL long has favored such a program, and with its adoption seemingly assured looks forward to much improvement in the carrying out of the work of the board of health. Not that there has been any fault to find with what has been done, but a reorganization such as planned will widen the field for our health officials, markedly increasing their authority to do things.

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On several occasions THE JOURNAL has commented on the fact that Hoosier physicians, long past the age of retirement, are as active as ever in these times of national need. We have many members well over the age of seventy who seem to have gotten their "second wind" and are going strong. Among those of whom we recently have heard is Dr. C. B. Goodwin, of Kendallville, who is almost eighty-three years of age, and, as a member of his county medical society puts it, "He is as agile as a man much younger." We also are advised that he always has been vigorous in his work, and during these war years more vigorous than ever. He graduated from the Kentucky School of Medicine in 1894, practiced in Rome City and Jeffersonville, and opened an office in Kendallville in 1899. He has been a member of the local board of health for twenty-six years, serving as secretary for some ten years. Thus do we record another name in our Hoosier Medical Hall of Fame, honoring another man who might have closed his office a long time ago, but who felt that he was too badly needed.

# President's Page

## PHYSICAL FITNESS

This issue of THE JOURNAL is devoted to the subject of "Physical Fitness" and it should, of course, be a reminder to all of us to do something about keeping our own stamina up to par.

The program outlined by the American Medical Association has, as its objective, the following points:

1. The evaluation of the physical state of young men and women.

2. Increasing the activities and responsibilities of schools and colleges in physical education.

3. Improving the opportunities for gaining physical health.

4. Enlisting the active support of industrial, social, religious, patriotic, professional, and other groups.

To conform with this movement your House of Delegates officially endorsed a new Committee on Physical Fitness to cooperate with and help the parent A. M. A. group in its effort to correct such evidence of physical unfitness as may become apparent from studies of this issue.

Needless to state that we have had another problem laid on our doorstep, because all of this activity stems from the findings of the Selective Service induction centers, which have indicated, in the large number of physical rejections, that there is a need for a nation-wide program aimed at the correction of these defects—the implication being, in the propaganda of the proponents of compulsory health insurance, that the medical profession has been dilatory in its obligations to the public.

The Indiana State Medical Association has set up a Committee on Physical Fitness to cooperate with the American Medical Association, which body is a member of the national group concerned with this problem.

At the head of our committee we have Dr. W. C. Moore, of Muncie, and assisting him will be Drs. W. C. Kunkler, of Terre Haute; George S. Bond, of Indianapolis; G. A. Thomas, of Lafayette; H. C. Wadsworth, of Washington; James H. Crowder, of Sullivan; C. R. Herd, of Peru; W. D. Little, of Indianapolis; and W. A. Thompson, of Liberty.

With that line-up we can hope for a physical fitness program that will again move Indiana into the spotlight of progressive medical associations.

You and I know that any breakdown of so-called "statistics" emanating from the Selective Service authorities reveals that 80 to 85 per cent of the defects causing rejection were not amenable to medical or surgical treatment. What the social workers and the proponents of compulsory health insurance did not consider were the factors of poor heredity, malnutrition, bad environment, neglect of teeth, and such things as poor parental care. The last item might well be indicated as the primary cause of physical unfitness, leaving out, of course, the cases of deformities due to fractures, and the inevitable results from infantile paralysis.

However, what I intended to say in this message is that you had better look after your own health. Doctors have a habit of neglecting their own physical welfare. This is not right, according to the standards set up for you; it is not right according to all the rules that govern our precepts and practice.

In spite of these difficult times, regardless of the demands on your activities, take time out to make yourself physically fit!

N. K. Forster

# THE WEALTH OF THE NATION IS IN THE STRENGTH OF ITS PEOPLE

JOHN B. KELLY

Chairman, National Committee and Council
on Physical Fitness, Federal Security Agency

WASHINGTON, D. C.

The slogan, "The Wealth of the Nation is in the Strength of Its People," adopted by the Committee on Physical Fitness of the Federal Security Agency, will, I fervently hope, soon become the slogan of every state, city, hamlet and community throughout our great country. Our naval and military leaders and many of our civilian officials agree that America can never again safely exist on the low level of physical fitness we knew at the time of Pearl Harbor. Facts which I will bring forth later in this article bear out that statement.

For the moment I wish to call attention to the need for the development of physical fitness in our children, and for the encouragement on the part of our government toward that end. We are going to entrust the peace we are now fighting for to our children and their children—the backbone of tomorrow's America. And in the true democratic American spirit we—today—must set up the plans and means whereby the generations that follow will be able to protect and preserve the peace for which thousands of American lives are being sacrificed.

I hope that national physical fitness legislation, proposed early this month by Congressmen Samuel Weiss of Pennsylvania, and Fred Hartley of New Jersey, will receive swift, hearty approval. As a whole—but not too thoroughly—the nation already realizes how weak its physical condition was when we entered the war. In this same degree it realizes the value of the Physical Fitness Program which has been projected to date. I believe it is now ready for the promotion of a program which will be much more far-reaching and active than the one which heretofore existed. What we need is a program incorporating the necessary money, facilities, and leadership to teach our youth, as early as the kindergarten age, the importance of physical as well as mental strength. I hope that our legislators (and I know some of them already understand the problem) will make possible an expanded program of physical fitness, entailing cooperation of federal and state governments, which will forever eliminate the excuses we have heard from schools in the past that "We have insufficient funds and inadequate facilities for physical education and training."

With the benefit of proper enabling legislation, American youth never again would suffer the neglect of its physical condition because of the necessity on the part of budget-harassed educators to make a choice between academic and physical training. In the past, our children all too soon found out that the school did not think vigorous play and sports activities important. Schools did not provide adequate play space, equipment and facilities, and leadership for the children entrusted to them the greater part of the day, and too often the space and equipment that was available was locked up after school hours.

At this point someone may ask, "But where will we get the necessary physical training leaders for the greatly expanded program of physical fitness?" Those of us who follow physical fitness closely have at least one answer ready. It is simply this: Thousands of highly efficient physical trainers have been developed in our armed forces during the past three years. These men, many of whom had no established vocation before the war, will return in quest of the work they have come to know and like best. A huge pool of physical training leaders virtually will be dumped into our laps. Hence, an expanded physical fitness program will put them into sorely needed jobs, and will help not only the establishment of deep-rooted physical training of our youth but, in addition, will fit nicely into the peacetime plans of President Roosevelt to provide jobs for all.

I have watched the German Youth Movement since 1920. If any of you have read the book, *Education for Death*, by Gregor Ziemer, you will have some idea of the extent of the German preparation for the war we are witnessing today. All the education in schools is practically two-thirds physical and one-third mental. Each boy and girl carries a book called *Leistungsbuch*, given to him at six years of age, with waterproof covering, and with a complete record of his physical condition and the various skills that he studies and practices, with the doctor's stamp at the bottom of each page.

From birth 'til six they are in the Pimpf. The six-year-old boy takes the examination for the Jungvolk. If he fails to pass the examination for the Jungvolk, he is made to feel he would be better off if he were dead. From six years of age until ten the boy is in the Jungvolk, which is really a regimented youth movement. At ten they move into another group which carries on to fourteen years of age. Graduating from that group, they go into the last group, from fourteen to eighteen years of age, and there they receive all the military and flying training, as well as navigation.

The German soldiers today are physically fit. When you see them in close-up pictures, you see

the results of rigid discipline and regimentation. They have given up their religions for a blind devotion to Hitler. They are said to kill off their delinquents, for they want a superior race.

America should continue to incorporate whatever is best from the world's store of athletic sports and other physical fitness activities into our democratic way of life. We must not lose our athletic and competitive ability, our sense of honor or our decency. I believe that our way is the best, because we really have something to fight for. Sports teach our boys initiative, fair play, teamwork, and develop in them the knowledge and courage to make split-second decisions. We are finding that a large percentage of the heroes in this war are men who have taken part in competitive athletics.

Some Americans have the idea that our wealth is buried in the vaults at Fort Knox, and that these bars of cold metal represent our national wealth. But I would say that our wealth is in the youth attending the schools, colleges, churches, and other organizations of our nation. That is our national bank—our great federal reserve. You can have Fort Knox for your security, but give me the youth of the nation for *my* investment. Since "the body is the temple of the soul," let us teach them to build an enduring structure, and one physically fit for service. This is essential for the perpetuation of the American way of life. My idea of education for youth is to make physically strong and mentally alert men and women—not weak-kneed, flat-chested mental giants. I would not sacrifice the physical for the mental, or vice versa; the two go hand in hand. But healthy bodies contribute to and fortify sound, alert minds. If we are to build strong, enduring bodies in our children, *more time must be given daily for this purpose.* All Americans should feel that every dollar invested in the health of the nation is money in the bank of America's future greatness.

Wartime service demands that our youth be strong and skilled beyond what is generally required in peacetime. I hope that after this war there will always be peace, but I am enough of a realist to state that only the strength and skill necessary to wartime service is the condition we can safely permit to exist hereafter. Observations by experienced persons in the field of physical training and draft statistics give every evidence that our youth was substandard and did not have the physical development demanded by the armed forces when the war came. We all know that

## COMPETITIVE ATHLETICS OUR GREATEST ASSET

WILLIAM F. FOX, JR.

*Sports Editor, The Indianapolis News*

INDIANAPOLIS

So you would like a statement regarding sports. Well, I have read many favorable words and phrases on the subject. I have also read as many words and phrases designed to undermine our system. If, when the jubilant Japs determined to butcher our boys, endeavoring to summon all their courage, endeavoring to do the impossible, charging with bayonets fixed, cried, "TO HELL WITH BABE RUTH!" need we go farther for a statement regarding sports? The Japs did not say, "To Hell with F. D. R."—they did not say, "To Hell with MacArthur"—they did not say, "To Hell with Halsey or Nimitz"—they said, "TO HELL WITH BABE RUTH!" In saying that they glorified our system of competitive athletics, our plan for sports, because they were out to utter defiance against our greatest asset—their greatest obstacle.

If you would like something a little more educational on the subject, listen to this paragraph from a story by L. A. G. Strong, a young Englishman who wrote a book called *The Garden*, which deals with the growth of a child.

"The love of boys for any form of athletics, and their veneration of the athlete, is a sound and natural thing; and those leaders are ill-advised who try to combat it. The boy proceeds from enthusiasm to enthusiasm, and it is bad psychology to try to force his transition from one phase to another. All that is necessary is that the materials for his successive enthusiasms should be within his reach, so that when he outgrows one he may easily pass on to the next. Athletics (or anything else) only become dangerous when there is nothing to succeed them, when a boy's elders all maintain with their prestige the same stage of arrested development, and, by implication, disparage all further stages. If, however, a boy must worship for a long time at one altar only, it is hard to think of a better one than skilled physical prowess. To play cricket or golf, to box or swim is an art. It demands sacrifices and incessant practice. It requires a sound technique. Great artists of this kind deserve more approbation from other artists than they commonly receive, but that is because, as with some musicians and many actors, the practice of their art has taught them nothing outside it; they remain inarticulate and undeveloped. So, fittingly, from the inarticulate and undeveloped they receive their deepest worship. Pursuing always a practical, tangible end—to strike more swiftly, more accurately, or to cut a second off their time—they exemplify in the simplest possible way the doctrine that man is here to overcome difficulty and to perfect his powers; and if there is a better lesson than that the schools have yet to find it."

when our young men were called, the first six months were spent in toughening them up. If an emergency ever arises again, I want our schools and colleges to have prepared our boys and girls, physically, and thus save that time.

A broad and vigorous physical fitness program, with adequate facilities in the community to keep it alive and going, is one answer to juvenile delinquency. Juvenile delinquency cannot be prevented by mere meetings and discussions among parents, teachers, and other adults. Delinquency activities are dangerously interesting and apealing to youth. One group of activities likely to have sufficient interest, adventure, challenge, punch, and pep to compete with the activities of delinquency is that of vigorous physical fitness games and sports activities. Schools must keep alive the natural interest children have in contests of strength, speed, endurance, and skill. They must make these things seem important at all levels of education. They must glorify the body and its possibilities and achievements—not neglect it or pretend that all other curricular subjects are superior to the training of the body.

In this war the United States has created the largest and best fighting force in history. But, from the records of some 13,000,000 physical examinations of men for the armed services, there has emerged as a by-product a picture of the health and physical fitness needs of this nation. It is a startling picture.

By December 1, 1944, men between the ages of eighteen and thirty-seven, who were physically disqualified for military service, totaled more than 4,450,000. Of these, 759,600 were counted unfit for military service because of mental disease, 620,100 for mental deficiency, and failure to meet minimum standards of intelligence, as prescribed by the armed forces after June 1, 1943. Another group of 469,300 was found to have manifestly disqualifying defects, and 67,700 were included in a list of non-medical defects. Among the causes for rejection of the remaining 2,542,000, in the order of their importance, were musculoskeletal defects, syphilis, cardiovascular (heart) disease, hernia, neurological disease, defects of the eyes and ears, and tuberculosis.

Not only did such defects, deficiencies, disabilities, disorders and diseases abound, but in addition many of the registrants were found to be soft and sadly in need of physical conditioning. Special training in physical fitness was necessary after induction, which represented weeks of wasted time and effort, much of which could have been avoided if every young man had been physically fit prior to induction.

Lack of physical fitness prevailed among the youth of the country because the nation failed to recognize its importance, and because youth failed to earn fitness.

The National Committee on Physical Fitness has published several brochures and has aided many groups in every state to set up the machinery whereby physical fitness may be attained. In the brief space of a year it has interested many national leaders and has harnessed together the interests, resources, and efforts of more than one hundred fifty national organizations.

Finally, the committee, realizing the value of the support of the medical profession, approached the American Medical Association with a view to securing their cooperation in a nation-wide emphasis on physical fitness. The outcome of this approach was the Joint Committee on Physical Fitness, in which the American Medical Association and the American Dental Association are cooperating with the Committee on Physical Fitness of the Federal Security Agency.

The knowledge of the medical profession concerning the physical fitness status of the people of the United States has been materially widened by the Selective Service experience. Medical examinations of Selective Service registrants has revealed the national needs. The time for meeting these needs is now. The boypower of today is the manpower of tomorrow. It must be physically fit.

The amazing conditions revealed by the Selective Service statistics, as to the physical fitness of the nation, is a challenge to the people in general and to the medical profession in particular; in fact, to all interested in national health and morale, and in the future of the nation and its youth.

Now, with sentiment among legislators growing in favor of expanded physical fitness, I look to the future, hopefully.

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## COVER PAGE

Almost ten thousand high school boys each year take part in the annual basketball tournament of the Indiana High School Athletic Association. The picture on the cover page is of the final round of the tournament held at the Coliseum, in Indianapolis, March 20, 1943.

For further information concerning the Indiana High School Athletic Association, see page 106.

# A MOSES IS NEEDED

H. C. WADSWORTH, M.D.*

WASHINGTON

When the target in the gallery goes "clank," nearly all of us turn our heads to see who is doing the "shootin'." When our feet hurt, our shoes are almost certain to receive our notice. The disqualifying of 36.2 per cent of our draft registrants woke up our government.

Competitive games in our high schools have had their place in the development of fighting men and young officers, commissioned as well as non-commissioned. Our commanding generals have frequently broken through the line, dived outside of tackle, and run wide around the end. Many a batallion commander has stolen the ball and interfered with his romp.

Our games have had untold influence on the social life of schools, yet we know that they have developed the latent physical talents of the few. Adults as well as youths enjoy the thrill and mass exhilaration of filled stadiums and community gymnasiums. It is American to watch competition and enjoy winning. Certainly no one can claim for competition great benefit to the physical development of the average boy or girl.

The success of our team captains and quarterbacks, college as well as high school, as leaders of men in our present war and in the first World War has been outstanding. Their resourcefulness and originality has been commended by our Allies. Their ability to cooperate and acquire Army discipline in such a short time has astounded our enemies.

Our efforts to induct the enlistment desired in our present military setup have been disappointing. The number of misfits and 4 F's has been quite a blow to our military authorities.

All authorities now know that Indiana has reached the place where contests in high school and college must be the culmination and not the purpose of our youths' physical training. All school, medical, and civil authorities must work together to weed out the harm of competition and the waste and futileness of much of our effort.

There is little harm in competitive training unless a school is unfortunate enough to have a coach and a principal who will risk the future health of a pupil for the sake of winning some all-important game over some "hated rival." This danger can be obliterated easily by placing the participation of one and all players in the hands of a trusted medical director. This director must have the right amount and the right kind of backbone.

The uptown, main-street and clubroom critics are hard to handle and to console when "Doc" lays off a "sure shot" because of a slight cold or a sprained arch. The fan knows not—neither does he care—the relationship between a sore throat and a rapid heart beat, with possible invalidism and futile existence twenty or thirty years later. Neither will two or three hours, or even five hours per week, of supervised calisthenics produce the eighteen-year-old boys and girls that we would like to see pass by on the streets of our Indiana towns.

The best physical directors and better-trained and increased number of assistants will not materially change the inelegant sitting posture or the shabby, loafing, hunchback walk of all too many young folk. There are too many underfed and improperly-fed children from six to twelve years of age for a few specialized teachers to do much for them after they have arrived at the high-school age. The physical director must have the full cooperation and help of all grade teachers if high-school students are to develop the muscle and bone which will enable them to walk or stand properly.

Perhaps it is time that the physical director should endeavor to correct the posture and carriage of each and every teacher in the school system. It is certain that no angular, underfed man or woman—aimless and without coordination—can be an inspiration either physically or mentally. I am also equally sure that the overfed, paunchy, or flabby can neither direct nor lead the young.

Teachers, physical directors, and coaches must have material—material properly seasoned and prepared. No child has control over his or her particular type of grandparents. Authorities—federal, state and local—must use every means available to assure the best parents possible. The better trained the parents are in hygiene and nutrition, the better trained and healthier is the pre-school child.

Home economics, widely taught as it is now, has produced great improvement in the food for the average home. Yet, through carelessness and forgetfulness too many three- and four-year-olds are sent out to play, wrongly fed. Too busy mothers send their children to school either overfed or underfed—why not see that nutrition and hygiene studies are required each year for all high school students? Why would it not be a good investment for school authorities to offer training to parents in hygiene, nutrition, and physical fitness?

Medical inspection, x-ray plates, wand-waving, vitamins, lectures, et cetera, will not give us physical fitness. It will require cooperation and constant work between health authorities, teachers, and parents—not for just an hour now and then, but daily—both in school and out of school, during the school term, and—all the more important—during vacations.

Hoosiers are prone to do things by "fits and starts," and then often overdo, or just as often

* Member of the Committee on Physical Fitness of the Indiana State Medical Association.

backslide. We must force ourselves to remember that it is a 'round-the-clock job, day in and day out, year after year. Physical fitness requires proper ancestry, food hygiene, sanitation, prophylaxis, medicine, and surgery.

Some job our Uncle Sam has undertaken! But better late than never. He has tackled it in time, I think. I wish him luck in his fight against habits, customs, conventions, and styles.

A wise man once said, "The way to educate a child is to commence with his grandfather." To assure "physical fitness" we must necessarily bring influence on the chromosomes, and even the genes, for generations.

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# HEALTH AND FITNESS IN THE SCHOOLS

FRANK S. STAFFORD

Principal Specialist in Physical Fitness
United States Office of Education

WASHINGTON, D. C.

In writing upon the subject of "physical fitness" it is necessary to point out that there are many definitions of fitness and many factors influencing its development. This article will be limited to a discussion of the public school fitness program. There have been many statements of the needs, aims and objectives for such a program. The National Council of Chief State School Officers at their annual meeting, December, 1944, passed the following resolution which states the needs for health and physical education in schools and educational institutions:[1]

"*Whereas* the national interest requires the best possible physical and mental health for every citizen, and

"*Whereas* this ideal is far from being attained at the present time

"*Therefore be it Resolved, That*

"(1) The Chief State School Officer of every State make every effort to develop an educational program which will be adequate to assure that every child will have the best possible physical and mental health.

"(2) That the cooperation of health authorities be obtained to:

"(a) Help each American to learn physical fitness needs.

"(b) Provide against preventable defects.

"(c) Attend to correctable defects.

"(d) Help each citizen learn how to live healthfully.

"(e) Get each person to act to acquire physical fitness.

"(f) Raise American standards of physical fitness.

"(g) Provide for adequate personnel, facilities, and time for such a program."

A committee of the Society of State Directors of Health and Physical Education, outlining the "War and Post-War Program in Health, Physical Education, and Recreation" for schools prepared the following statement of aims and objectives:[2]

"1. To develop physical and organic vigor; provide neuromuscular training; promote bodily and mental poise; correct and prevent postural and bodily defect; and to develop correct body mechanics and mental and physical alertness.

"2. To secure the more advanced forms of coordination, strength, endurance, agility, and balance.

"3. To promote the more desirable moral and social qualities, such as an appreciation of the value of cooperation under leadership, self-subordination, obedience to authority, higher ideals, courage, self-reliance, disciplined initiative, self-control, and a wholesome and robust interest in recreational activities.

"4. To promote a hygienic school, home, and community life by securing scientific inspection and supervision to assure safe and sanitary school buildings, playgrounds, and athletic fields, including equipment.

"5. To provide a health service program which assures protection from communicable disease, first aid, medical examination, daily inspection of pupils by teachers, health records, attention to those who need medical and dental care, and special education for handicapped pupils.

"6. To provide suitable instruction in personal and community health and safety, so that the individual will develop an understanding and an appreciation of the basic facts of health and disease; will protect his own health and the health of his family, community, and nation."

The platform of the American Association for Health, Physical Education, and Recreation, adopted in 1942, states:[3]

"1. As shown by the draft, approximately 50

[1] *Education for Victory*, "National Council of Chief State School Officers—Report of Baltimore Meeting," Washington, D. C., U. S. Office of Education. Vol. 3, No. 12, December 20, 1944. P. 4.

[2] *The Journal of Health and Physical Education*, "War and Post-War Program in Health, Physical Education and Recreation," Washington, D. C., National Education Association. Vol. 16, No. 2. February, 1945. P. 63.

[3] *A Bill of Rights for Childhood and Youth in Health Education, Physical Education, Recreation*, Washington, D. C., National Education Association. April, 1942.

per cent of American youth have disabling defects, hence

It is necessary to have medical examinations for every young person of school age, the type of examination and the organization necessary to be determined by organized medicine and public health.

"2. The neglected defects in childhood are the same defects which prevent acceptance for service, hence

It is important to secure the early correction of every remediable defect, the ways and means to be determined by the family and the community.

"3. Many young persons violate health practices because they do not know how to live, hence

There should be emphasis upon rest and sleep, nutrition, recreation, exercise, mental and social hygiene, medical and dental care in order to develop desirable patterns of living.

"4. Many children fail to grow properly, are weak, are unable to protect themselves adequately in emergencies, and lack recreational skills, hence

All children should be taught motor skills which promote growth, development, safety, and recreation suitable to age, sex, and condition of health. A program of physical education consisting only of weight-lifting, strength stunts, calisthenics, marching, or similar exercises is too limited for the needs of growing boys and girls.

"5. The things children learn in school should function in their lives now and afterwards in civilian life, hence

The program should consist of rhythms, games, sports, athletics, and body-building activities, the latter directed particularly to the arms and upper back. The program should extend competitive interschool athletics suitable for individuals concerned.

"6. There are many desirable facilities and opportunities in the community, hence

In conjunction with the regular program of the school, wide use should be made of community and state facilities and opportunities for camping, hiking, riding, boating, and other similar outdoor activities.

### Health Guidance and Counseling

To realize the above-stated objectives, every school should have a Health Guidance and Counseling Program, which provides every pupil with a thorough medical examination upon entrance into school and periodically thereafter to the end that remediable defects and handicaps can be discovered and corrected. This program should also assure instruction in the prevention and control of communicable disease, including the importance of immunization for smallpox, diphtheria, and typhoid fever, and it should assure an understanding of the need for appropriate testing for tuberculosis and venereal disease. As a part of this program, the school should assume some responsibility for providing the pupils and parents with information regarding appropriate sources of medical and surgical services.

Pupils should be assigned to physical education activities in accordance with the entering or subsequent physical and medical examinations, and no activities should be prescribed or elected except as the physical fitness of the pupil warrants. An adequate seasonal examination should be made by a regularly-licensed physician of all varsity and intramural athletes prior to the pupil's first practice for any athletic contest. Any pupil who is absent from school for five or more consecutive days due to illness or injury should be required to present, before participation in class activities, a statement from a regularly-licensed physician, indicating that he is physically fit to participate in vigorous physical activities.

The Health Guidance and Counseling Program should also help students improve their personal nutritional status, according to individual needs. This part of the school program should assure that the school lunch provides its share of the daily food requirement, and that each student gets an adequate noon meal.

This Health Guidance and Counseling Program should aid in the development of sound mental attitudes, provide for guidance to assist with the problem of planning a daily program for balanced living, and it should assist in the provision of adequately-trained personnel to assist in giving emergency care.

### Health Instruction

Graded health and safety instruction should be provided for all pupils in all elementary grades. The high schools should offer as a minimum a one-hour course of daily health and safety instruction. Every pupil should be provided with an opportunity to develop a better knowledge and control over his individual practices of hygiene. High school pupils should be offered instruction in such aspects of military hygiene as disease control, recreation, and psychological adjustments. Every pupil should be given adequate and appropriate instruction in the prevention, care, and treatment of all communicable diseases, with special attention to venereal disease, social and filial relationships, and sex education.

Every opportunity should be taken in physical education activity classes to instruct pupils in the hygiene of the activity, and to give instruction through suggestions in methods and principles of effective health behavior. The content of the Red Cross courses in first-aid, home nursing, and life-saving should be included as a part of each pupil's health and physical education.

### The Activity Program

The content of the program in physical education should offer ample opportunity for youth to achieve a sound physical condition through participation in vigorous activities. The objectives of strength, endurance, coordination, and agility should be held

clearly in view, and individual programs should be arranged so that each pupil can obtain these goals whenever compatible with the age and condition of the pupil. The program should include activities selected and adapted to meet the needs of all pupils, including those with physical handicaps.

Wherever feasible, schools should make their facilities available and should organize instructional and recreational groups for the whole community, with special classes for individuals needing rehabilitation. Physical education periods should be organized so as to allow and utilize the maximum amount of time for vigorous participation. Administrators should recognize that for the normal pupil one hour of vigorous activity per day would be a minimum amount of time necessary to produce the desired results.

School faculties and other employees should be urged to avail themselves of the physical education facilities, with periods or classes set aside for them, and the administrator should arrange the program so as to provide for convenience in attendance.

Since the minimum essentials of various phases of a complete school health program are outlined in many state courses of study and in publications of the United States Office of Education,[4] these minima will not be listed in this article.

### Teacher Education

A real problem that must be faced by school administrators and colleges and universities, is the training of personnel for the organization, administration and instruction necessary to provide an effective program for the development of pupil health and fitness. The problem of teacher training for health and fitness is specifically the responsibility of teacher-training institutions. However, since members of the medical, dental and nursing profession and other official agencies, such as Health Departments, Welfare Departments, public clinics and hospitals, are concerned with the health problems of society, the members of their staffs have some responsibility for aiding in the training of teachers for effective health education. Cooperative action and planning between all of these agencies is essential. State departments and the colleges and universities should provide the leadership necessary to secure the maximum contribution that each of these groups can make to the professional preparation of school health personnel.

### Coordination Essential

In the different states the legal responsibility for specific phases of the health program has usually been delegated to the health, welfare and education departments. Other departments and commissions may have been delegated the responsibility by law of providing leadership, facilities, and services which contribute to the general health and welfare. Often legal and moral responsibility for the specific phases of a program that cuts horizontally across the sphere of interest of different official agencies creates enormous administrative problems and many overlapping functions. This may result in waste, hostility and interprofessional conflict. However, overlapping function should not be seen as a waste, but as an opportunity for teamwork against a common foe. Interprofessional conflict should not be seen as hostility, but as proximity that in itself has value.

[4] (a) *Physical Fitness through Physical Education for the Victory Corps,* U. S. Office of Education, Victory Corps Series Pamphlet No. 2. Price 25c.

(b) *Physical Fitness through Health Education for the Victory Corps,* U. S. Office of Education, Victory Corps Series Pamphlet No. 3. Price 20c.

(c) *Handbook on Physical Fitness for Students in Colleges and Universities,* U. S. Office of Education. Price 25c.

(Note: These publications are for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.)

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## INDIANA HIGH SCHOOL ATHLETIC ASSOCIATION

The Indiana High School Athletic Association probably has had more to do with the development of a physical fitness program than any other group in Indiana. It was founded in 1903.

Beginning in 1913, Arthur L. Trester served as head of this organization. As such he developed principles in regard to the conservation of health, which have resulted in immeasurable benefit to the youth of Indiana.

Mr. Trester died after thirty-one years of service, and was succeeded by L. Virgil Phillips, of Vincennes, formerly principal of the Vincennes High School. Mr. Phillips is a member of the Executive Committee of the National Education Association, and is welcomed to the position of commissioner by all those interested in the education and health of the youth.

# A MESSAGE ON PHYSICAL FITNESS

CAPTAIN C. RAYMOND WELLS, D. C., U. S. N. R.

National Headquarters, Selective Service System

WASHINGTON, D. C.

## HEALTH

*To get his wealth he spent his health*
*And then with might and main*
*He turned around and spent his wealth*
*To get his health again.*

The emphasis of the United States in preparedness for national defense during the past decade, and an even greater emphasis on the procurement of manpower following Pearl Harbor, focused attention on the need for physical fitness among all the people of the nation. The millions of physical examinations conducted by Selective Service and the armed forces disclosed a high percentage of physical defects among the youth of the nation. The readers of this JOURNAL are by now quite familiar with the various statistics on this matter, which have been published from time to time in the newspapers and professional journals. Therefore, it will not be necessary to quote any rejection figures. Suffice it to say, as a result of the study of rejections, for various physical reasons, the nation was awakened to the need for greater emphasis on the physical fitness of their citizens. The nation had become increasingly sports-minded, but until the statistics revealed a mass of physical defects the people approached the matter in a passive way. There is now a definite need to acquaint the citizenry with the need for active participation in recreation, sports and games for all, both young and old and for both sexes. Physical educational programs are needed in various communities, especially in the schools—programs that will help make and keep our people fit. The purpose of this program is not only to prepare for military service alone, but to enable the people to carry out their daily work tasks.

With this viewpoint in mind, the American Medical Association joined with the National Committee on Physical Fitness of the Federal Security Agency on July 14, 1944, to promote greater emphasis on physical fitness. The Committee formed is known as the Joint Committee of the American Medical Association and the Committee on Physical Fitness of the Federal Security Agency. Members on the Committee consist of representatives of the American Medical Association, the American Dental Association, physical educators, and representatives of labor management. The Chairman of the Committee is Colonel Leonard G. Rowntree, chief of the Medical Division of the Selective Service System, and a distinguished member of the medical profession. The committee has met several times and through various media is increasing the interest of the public in physical fitness. The emphasis must start with children and continue into the whole pattern of schools, civic and church groups, medical and dental profession, labor management, sports and promotional groups. It is believed that this movement will result in successful programs for better health and physical fitness.

In any program designed to emphasize physical fitness, both the American Medical and American Dental Associations must play an active part. Hand in hand with physical fitness must go medical and dental supervision and care in order that those participating in physical fitness programs may attain good health necessary for the participation.

Physical fitness programs for people with physical defects and handicaps can be provided, but only after advice is sought from the medical practitioners as to the degree and scope of participation. If left to the individual himself he may engage upon activities which are too strenuous for physical condition or handicap. For instance, a young man may decide to become a football player when actually he is not medically or physically fit to engage in this strenous sport. However, with sound medical advice he can be directed to other fields of sport and exercise into which he would fit admirably, and where he can receive full enjoyment as well as physical development. It is at this point that there must be cooperation between the physician and the physical educator.

Physical fitness is a distinct challenge to the United States in any postwar program being planned for the people. Every means of publicizing physical fitness should be utilized. The place to start any program in physical fitness is in our various educational institutions. In *Education for Victory*, the official biweekly journal of the United States Office of Education, of December 20, 1944, appeared the following part of a resolution which should be of interest to every citizen:

1. That the cooperation of health authorities be obtained to:
   a. Help each American to learn physical fitness needs.
   b. Provide against preventable defects.

* Member of Joint Committee on Physical Fitness, of the American Medical Association and the National Committee on Physical Fitness.

c. Attend to correctable defects.
d. Help each citizen learn how to live healthfully.
e. Get each person to act to acquire physical fitness.
f. Raise American standards of physical fitness.
g. Provide adequate means for physical development.

2. That the program which is developed should provide for the following:
a. Preadmission physical examination at five years.
b. Periodic examination at appropriate intervals thereafter.
c. Education in principles of healthful living.
d. One hour daily for physical training.
e. Credits for satisfactory progress.
f. Accumulative health and physical records.
g. Provision for adequate personnel, facilities, and time for such a program.

As the dental member of the Joint Committee, I am privileged to relate where the dental profession fits into this program. It is axiomatic today that dental fitness is a definite and important part of physical fitness. Dental disease is prevalent in ninety-five per cent of the people of the United States and requires treatment if the people are to be physically fit. Dental infection and oral diseases play a vicious role in the health of the people. The high rejection rates in the early days of Selective Service showed the great need for dental care among registrants. The rate of rejection became so high that dental standards for acceptance were lowered to such an extent that the armed forces had to commence the greatest dental rehabilitation ever undertaken within the services.

In cooperation with the various school systems of the country, the dental profession entered enthusiastically into the Victory Corps program, of which most of us are familiar. In numerous states the Victory Corps program was publicized through official educational, health, dental and other journals, radio talks, and local newspapers. Dental divisions of various state health departments and bureaus of public relations furnished dental health posters and films and other methods for implementing the program. Special attention was given to the high school group in order that they might better fit themselves for service and work in the great war effort. The program will be repeated again in this year of 1945. However, this Victory Corps program is being integrated into the nationwide physical fitness program, and dentistry now calls it the Physical Fitness Dental Health Program. It is long range and designed to establish friendly and effective working relationship among all groups interested in physical fitness on local, state, and national levels. A high percentage of dental corrections are for pupils of high schools in various localities of the nation. A sustaining program to encourage dental fitness will do much to promote physical fitness. Prevention should be the keynote of the future, and the sound physical fitness program is designed to promote this. Never again should we be faced with the immediate need for the correction of a multitude of dental and physical defects to make our people physically fit.

Both the American Medical and American Dental Associations must assume and continue leadership in the field of physical fitness. A neglected body hinders the attainment of the highest capacity possible to the individual. The physicians and dentists of the nation must take their rightful place in this great and needy field.

*(The opinions and assertions contained herein are the private ones of the writer and are not to be considered as official or reflecting the views of the Navy Department or the Naval Service at large. [Article 113, Navy Reg.])*

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## Books

**MEDICAL USES OF SOAP.** (A Symposium) Edited by Morris Fishbein, M.D., 182 pages with 41 illustrations. Price, $3.00. Fabrikoid. J. B. Lippincott Company, Philadelphia, 1945.

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**ARTERIAL HYPERTENSION.** Its Diagnosis and Treatment. By Irvine H. Page, M.D., and Arthur Curtis Corcoran, M.D., of the Research Division of the Cleveland Clinic Foundation, Cleveland; formerly with the Lilly Laboratory for Clinical Research, Indianapolis City Hospital, Indianapolis. 352 pages with 14 illustrations. Price, $3.75. Cloth. The Year Book Publishers, Incorporated, Chicago, 1945.

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**THE 1944 YEAR BOOK OF INDUSTRIAL AND ORTHOPEDIC SURGERY.** Edited by Charles F. Painter, M.D., Orthopedic Surgeon to the Massachusetts Women's Hospital and Beth Israel Hospital, Boston. 432 pages with 282 illustrations. Price, $3.00. Fabrikoid. The Year Book Publishers, incorporated, Chicago, 1945.

**THE MARIHUANA PROBLEM IN THE CITY OF NEW YORK.** By the Mayor's Committee on Marihuana. 220 pages. Price, $2.50. Cloth. The Jacques Cattell Press, Lancaster, Pennsylvania, 1944.

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**MICROBIOLOGY AND PATHOLOGY.** (Third edition.) By Charles F. Carter, M.D., Instructor in Microbiology and Pathology, Parkland Hospital School of Nursing, Dallas, Texas; Director, Carter's Clinical Laboratory, Dallas, Texas. 777 pages with 200 text illustrations and 25 color plates. Price, $3.50. Fabrikoid. The C. V. Mosby Company, St. Louis, 1944.

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**THE ETIOLOGY, DIAGNOSIS, AND TREATMENT OF AMEBIASIS.** By Charles Franklin Craig, M.D., Colonel, United States Army, Retired, D.S.M. Late Commandant, Army Medical School, and Assistant Commandant, Army Medical Center, Washington, D.C. Emeritus Professor of Tropical Medicine, Medical School, Tulane University of Louisiana, New Orleans, Louisiana. 332 pages with 45 illustrations. Price, $4.50. Cloth. The Williams & Wilkins Company, Baltimore, 1944.

# Military News

Lieutenant Colonel Benjamin F. Pence, of Columbia City, has been transferred from Africa to France, and is on duty with a station hospital there.

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A captaincy has been accorded Dr. Herbert S. Dieckman, of Evansville, who is serving somewhere in France.

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Captain Ernest L. Dietl, of South Bend, has been quite busy working with "a very good group of doctors." At the time that he wrote, he was planning a trip to Scotland.

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An APO-address card has been received from Captain R. B. Smallwood, of Bedford, indicating that he has gone abroad. He was formerly in San Francisco.

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We are sorry to report that Lieutenant J. C. Ambrose, of Noblesville, has suffered a serious leg injury in the Southwest Pacific war zone, where he has been for more than a year. Lieutenant Ambrose is on duty with the United States Navy.

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After training at Camp Atterbury, Indiana, Captain Stuart R. Combs, of Terre Haute, has recently gone overseas with a field hospital. In the same group was Captain W. E. Jenkinson, of Mount Vernon.

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While being transferred from Camp Davis, North Carolina, to Camp Shelby, Mississippi, Major Roger W. Brookie spent a few days leave at his home in Flora. Major Brookie is now assigned to the E.N.T. Department of the Regional Hospital at Camp Shelby.

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We are pleased to report that relatives of Lieutenant Basil B. Dulin, who has been held in the Philippine Islands as a prisoner of the Japanese for several months, have received a prison camp form card from him, advising that he is in good health. Lieutenant Dulin graduated from the Indiana University School of Medicine in 1940.

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Captain Henry M. Pickard, of Elkhart, has been with a medical battalion in the European Theater since August, 1942. On the occasion of their second anniversary overseas, *The Stars and Stripes* wrote: "This battalion has followed . . . the retreating Germans from Africa through Sicily, and far up the Italian Peninsula. In its evacuation operations the battalion has transported 101,210 patients, a total of 1,430,465 patient-miles, described as an outstanding record of its kind."

We are pleased to report that Dr. C. B. LaDine, of Indianapolis, has been promoted to lieutenant colonel. Colonel LaDine is the executive officer of a general hospital located in France.

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Lieutenant Colonel J. W. Bowers, of Fort Wayne, has moved from the Veterans Administration at Dayton, Ohio, to the Mayo General Hospital at Galesburg, Illinois.

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Captain Larkin D. Denton, of Greentown, has apparently gone overseas with a general hospital, since his address has been changed from Camp Barkeley, Texas, to a New York A. P. O.

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Captain Ctis R. Lynch, of Marengo, who had been stationed at Fort Warren, Wyoming, reports that he has been transferred to Camp Cooke, California.

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A newly-created post of preventive medicine, as the beginning of an expanded program of public health education, has been filled by the appointment of Dr. Gerald F. Kempf, of Indianapolis. Dr. Kempf is research physician in the Lilly Laboratory for Clinical Research at the Indianapolis City Hospital.

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### ARMY'S MERCY FLEET

Five more troop ships have been stripped of their armament and converted into United States Army hospital ships, in order to insure speedier return of America's combat wounded, the War Department announced recently. Addition of these new ambulance-type hospital ships will bring to twenty-nine the number of such vessels operated by the Transportation Corps, Army Service Forces. These vessels will have a total patient capacity of more than eighteen thousand.

*The United States Army Hospital Ship, Emily H. M. Weder, formerly the President Buchanan, was converted into a hospital ship on July 5, 1944. This vessel has a total patient capacity of approximately seven hundred. Like all President ships, it is 502-ft. long, has a gross tonnage of 10,533, and a speed of thirteen knots. This ship was named after Major Emily H. M. Weder, who served as a regular Army nurse from the first World War until her death in 1943.*

On duty with a collecting company, Captain Raymond E. Nelson, of South Bend, is serving in Italy. Although facing another Italian winter, it does not get too cold in that particular part of the country, he reported, but it does rain almost daily, and in the mountains there is much snow. The war there is getting to be quite a cosmopolitan affair. While attending a theater operated by the American Army, Major Nelson sat between a Brazilian and a Frenchman, and witnessed a show presented by an R.A.F. cast. In the audience were Canadians, Poles, Yugoslavs, and South Africans.

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A letter from Dr. Earl E. Parker, of South Bend, who is on duty in the South Pacific, states: "We have so little on this base to remind us of civilization. Just to walk down a paved street and see a dime store or a filling station would be a big lift. However, this base is almost extinct. Since nine months overseas does not seem to be enough to make one eligible to return home, I will be glad to see a change of scenery. Our summer is just starting here, so it is somewhat hotter than when we arrived. But we get through it without too much difficulty. Have been working in a dispensary for the last three months, at a rotation camp where men overseas thirty to thirty-six months are awaiting shipment to the States."

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A letter from Lieutenant Commander E. Rogers Smith, of Indianapolis, written shortly before Christmas, has just reached our office. We thoroughly enjoyed reading it, and think that others will, too; hence we take the privilege of quoting it: "For weeks and perhaps months I've been intending to send you a 'Report from the Troops,' but it takes the reactive depression of approaching holidays to goad me to activity. In fact, it takes some low-down active goading. As I sit here 'high above radio hill in the New Hebrides,' as our station A. E. S. says, I look out into the palms and try to imagine putting tinsel and candles on a sweet little cocoanut palm—and it sure brings out all the Scrooge in me. But far be it from me to protest over being in this nice little country club. We are finishing up our sixteenth month—seven here and nine in New Zealand, and if you think that's a tough war, you're crazy. I assure you that it has been a pleasant vacation compared to the practice of medicine. I wonder if I'll ever have to go to work again. The thought appalls me.

"Our skipper, the one who brought us out, has been placed in command at the new psychotherapeutic center in San Leandro, California, and we expect to join him in the spring—we hope. It sounds like a perfect setup—far nicer than Guam or Leyte. Funny how little interest I have in those rugged places. If they ever dropped me on one of those beaches, I'd be called 'Mole' Smith as I tunneled my way through the coral."

Captain Jack Reiss, of Indianapolis, with an airborne medical company attached to the famous airborne division cut off at Bastogne, was the sole medical officer from his company in the recent siege. Captain Reiss told of seven days and nights when he worked constantly. He said, "Finally the encirclement was broken, and on December twenty-ninth I was relieved and went back to camp.

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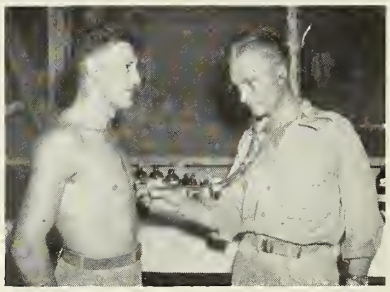
"I have been with the Air Force since arriving overseas," writes Captain Harold J. Stoen, of Lafayette, who is now on duty in the Philippines as squadron surgeon at headquarters of a veteran jungle air force. "We spent a few months in the Netherland East Indies before arriving here. While there we had some interesting experiences and witnessed a great many bombings and strafings from the 'Nips.'



*Captain Harold J. Stoen Checking Physical Fitness in his squadron.*

"We are getting acquainted with some new diseases here. Schistosomiasis is very prevalent. All fresh water is heavily infected. The eosinophile count goes as high as 78 per cent on a differential count in this disease.

"The soil is heavily infected with hookworm, due to poor sanitary habits of the native population. Stool specimens from natives are 60 to 90 per cent infected with one parasite or another.

"Here, and other places where we have been, we have seen yaws, filariasis, amebic dysentery, malaria, tropical ulcers, fungus infections of all types, and the usual run of tropical diseases—dengue, et cetera."

From a press release which has recently come to this office it would seem that not all of Captain Stoen's work is concerned with treating tropical diseases, for he has received a commendation, signed by the commanding general of the Air Force with which he serves, for his courageous actions during an attack by Japanese bombers, when he left his place of shelter to aid his men without thought of his personal safety. The release states:

"It's a high honor, getting a commendation from a two-star general, but the men he risked his life to help say it is no more than he deserves. The night he won the commendation Captain Stoen left his foxhole immediately after a bomb fell a few yards away. He searched for the wounded and gave them first aid while enemy bombers droned overhead and deadly flak fragments rained down. His calmness, judgment and unhesitating actions during the attack were extremely praiseworthy."

Major Kenneth B. Fisher, of South Bend, has been transferred to the Medical Department School at Fort Benjamin Harrison, where he started out in February, 1941. Captain Jacob Rosenwasser, of Mishawaka, also is on duty there, and their work is that of teaching.

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A newcomer to the Navy is Dr. Emil Rothstein, who has been commissioned as a lieutenant. Formerly assistant medical director of the Indiana State Sanitarium, at Rockville, Lieutenant Rothstein is now at the Naval Training Hospital, Sampson, New York.

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"Major" is now the title for Fielding P. Williams, of Huntingburg, who is in charge of a hospital unit in the Philippines, according to word received by his family. Best of luck, Major Williams.

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A change-of-address card from Colonel Oliver W. Greer, of Indianapolis, indicates that he has left Camp Breckenridge, Kentucky, for an overseas destination.

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Since returning to the Caribbean area, after a leave, Major William A. Paff, of Elkhart, has been doing medical and administrative work at the hospital where he is stationed.

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Captain W. J. Fuson, of Greencastle, who has been stationed near London, reported that he had had the privilege of attending the Royal Academy of Surgery held in London, and was attached to the EENT Division.

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"I am now assigned to the surgery service here in the Regional Hospital, at Fort Leonard Wood, Missouri," writes Captain V. K. Stoelting, of Winchester, "getting plenty of work but looking forward to being a civilian some day." We hope that day will soon be here, Captain Stoelting.

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We appreciated receiving a change of address for Lieutenant (j.g.) Woodson C. Young, of Indianapolis, and some information concerning his whereabouts, which are so interesting that we quote a part of his letter herewith:

"I am now in the Navy and am connected with Civil Affairs on one of the islands in the Marianas. I am directly connected with the civilian hospital, and have an opportunity to see a lot of sick patients. There is an amazing amount of acute pulmonary disease here among the natives. There is also a large amount of tuberculosis. I guess our greatest problem is, however, intestinal parasites, secondary anemia, and malnutrition. Vitamin deficiencies are prevalent, especially B. Many of these require hospitalization. We feel forunate if we get a good healthy blood donor with a hemoglobin of 70 per cent. I have no complaints to offer as I feel I have excellent duty."

Major William Deutsch, of Muncie, has just returned from North Africa and Corsica, and is now stationed at Billings General Hospital, Fort Benjamin Harrison, Indiana. While overseas he saw Major John Palm, of Brazil.

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Dr. Paul G. Iske, of Indianapolis, has been promoted to lieutenant colonel, and been made the executive officer of a station hospital in New Guinea. Colonel Iske has been stationed at this hospital ever since arriving overseas, and has helped to build it from its very beginning. While actual numbers cannot be mentioned because of censorship restrictions, the bed capacity is quite large, and we feel that another Indiana doctor has reflected credit upon his state. Congratulations, Colonel Iske!

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The St. Joseph County Medical Society *Bulletin* has published excerpts from letters written by Major George F. Green, of South Bend, who states: "We have been giving our candy rations for a couple of weeks to the British children. They don't get much. Our hospital is running at full capacity. Did an interesting gas gangrene case today, and saved the leg. Have loads of surgery to do. We heard the Michigan-Ohio game last week, and the Army-Navy game Saturday. Good broadcast, starting hours after dark. Weather is peculiar, rains any time just from any one cloud that happens along. Would like to have some . . . —noncombatants cannot buy clothing." Major Green is stationed in England.

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At a United States Troop Carrier Base, somewhere in France, a captured German trailer that was used to house staff officers of the Luftwaffe near the front lines now serves Captain Marion M. Crum, of Angola, as his squadron dispensary. Captain Crum, a troop carrier flight surgeon, is shown with his staff in the accompanying photograph.

*Captain Marion M. Crum and squadron dispensary staff.*

# News Notes

Dr. Frank P. Albertson, of Trafalgar, has returned from overseas, and can be reached at Indianapolis.

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Formerly at Batesville, Dr. Lester H. Hopkins has opened offices at Versailles, to be known as the Hopkins Clinic.

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Dr. Maurice S. Fox, formerly of Bicknell, has completed his postgraduate study and opened an office in Vincennes for the diagnosis and treatment of allergic diseases.

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Dr. Samuel C. Murphy and Miss Hazel Jamison Melick, both of Warsaw, were married on January ninth. Mrs. Murphy was head nurse at the Murphy Medical Center, of which Dr. Murphy was the founder.

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Dr. William E. Ballenger has recently been given a medical discharge from the Army Medical Corps, and has resumed his practice of ophthalmology and otolaryngology in the Medical Arts Building, at Richmond.

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Dr. Ira L. Faith, Jr., of Indianapolis, and Miss Norma Lee Helm, of Evansville, were married January fourth at the Simpson Methodist Church, in Evansville. Doctor Faith is a graduate of the Indiana University School of Medicine, and is interning at the Indianapolis City Hospital, where Mrs. Faith is a member of the nursing staff.

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### MEDICAL AND SURGICAL RELIEF COMMITTEE OF AMERICA

The Medical and Surgical Relief Committee of America announced that for the six-month period ending December 31, 1944, the Committee's donations to twenty-one countries, including the United States, amounted to $43,669.87.

The territory covered by the Medical and Surgical Relief Committee has increased as the number of liberated countries has increased, and contributions now reach France and Italy. The United States tops the list of beneficiaries. The greatest number of shipments for this period went to China and India, while the most valuable single contribution amounting to $4,951.76 went for the relief of French children.

The Medical and Surgical Relief Committee is distinguished by its adherence to two principles: (1) No authentic appeal is ever turned down; and (2) medical aid is the only form in which aid is given. Contributions of medical, surgical and dental supplies and instruments will soon reach the $700,000 mark.

The Citizens Committee of the Senate Avenue Y.M.C.A. sponsored a banquet on January thirtieth, honoring Dr. Sumner A. Furniss, who has been a practicing physician in Indianapolis for fifty years. Given on Dr. Furniss' seventy-first birthday, the dinner was attended by more than three hundred guests. Speakers included Governor Ralph F. Gates, Mayor Robert H. Tyndall, Dr. S. C. Alexander, of New Albany, and Dr. Norman Jobes, of Indianapolis. Dr. Furniss graduated from the Indiana Medical College, in 1894, and was the first colored intern at the Indianapolis City Hospital, having served his internship there in 1894-95. Governor Gates declared that Dr. Furniss stands as a "shining example that those born under humble conditions can rise to great community respect through unselfish endeavor and faithful service."

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## INDIANA UNIVERSITY NEWS NOTES

Dean W. D. Gatch, of the Indiana University School of Medicine, was the principal speaker at the opening meeting of the Madison County Cancer Control Organization, at Anderson. "The Prospect of the Cancer Patient Today" was the subject of Dean Gatch's address. The meeting was attended by representatives from all parts of Madison County, as well as by delegations from other Indiana cities.

*(Our paper situation necessitated omission of some news notes, which will be published in the next issue.)*

### RADIO CALENDAR

"YOUR HEALTH IN WARTIME"

Hear these broadcasts each week:

Indiana State Medical Association—Doctor Good-health—Monday, 3:30 P.M., WFBM, Indianapolis

Elkhart County Medical Society—Wednesday, 4:30 P.M., WTRC, Elkhart

Vigo County Medical Society—Thursday, 12:15 P.M., WBOW, Terre Haute

St. Joseph County Medical Society—Friday, 1:45 P.M. WSBT, South Bend

Howard County Medical Society—Friday, 6:30 P.M., WKMO, Kokomo

Vanderburgh County Medical Society—Saturday, 10:00 A.M., WGBF, Evansville

# Deaths

**Horace Russell Frank Allen, M.D.,** of Indianapolis, died February twelfth at his home, after an illness of approximately one month. He was seventy-six years of age. Doctor Allen was a graduate of the Columbia University College of Physicians and Surgeons, New York City, in 1895. During World War I, Doctor Allen was a major and served as medical director of the medical school at Fort Oglethorpe, Georgia, where he taught a class of more than two thousand five hundred young surgeons. He later was attached to the surgeon-general's office. In addition to his practice as an orthopedic surgeon, Doctor Allen was chief surgeon at the Indianapolis Motor Speedway for twenty-seven years. He was a member of the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**Harvey Christian Bowers, M.D.,** of Akron, died February eleventh from injuries sustained in a traffic accident. Doctor Bowers was seventy years of age. He was a graduate of the St. Louis University School of Medicine in 1902.

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**Omer U. Carl, M.D.,** of Peru, died January fourteenth, after an illness of short duration. Although in poor health, he had continued his practice up to the time of his death. Doctor Carl was a graduate of the Miami Medical College, Cincinnati, in 1896, and had practiced medicine in Peru since 1903. He was seventy-two years of age. Doctor Carl was a charter member of the Miami County Medical Society, a member of the Indiana State Medical Association, and a Fellow of the American Medical Association.

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**Ira C. Willan, M.D.,** of Morgantown, died January twenty-ninth at the age of eighty-five. Doctor Willan was a graduate of the Medical College of Indiana, Indianapolis, in 1883, and had practiced medicine for sixty-two years.

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**Robert O. McAlexander, M.D.,** of Indianapolis, died January twelfth at the age of seventy-seven. Doctor McAlexander graduated from the Medical College of Indiana, Indianapolis, in 1896, and had practiced in Indianapolis for forty-seven years. He was especially interested in gynecology. Doctor McAlexander was a member of the Indianapolis (Marion County) Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

**Law Erskine Somers, M.D.,** of Fort Wayne, died unexpectedly of a heart attack on January twenty-first. He was fifty-six years of age. Doctor Somers was a graduate of the Indiana University School of Medicine, Bloomington, in 1917, and was a veteran of World War I. He was especially interested in surgery. Doctor Somers was a member of the Fort Wayne (Allen County) Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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**John Hamilton Nye, M.D.,** of Cromwell, died on January ninth, at the age of seventy-seven. He was a graduate of the Medical College of Indiana, Indianapolis, in 1892, and had practiced in Cromwell for nearly half a century. Doctor Nye was especially interested in pediatrics. He was a member of the Noble County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**Samuel Casper Murphy, M.D.,** of Warsaw, died February tenth after an extended illness. He was fifty-nine years of age. Doctor Murphy was a graduate of the Indiana University School of Medicine, at Indianapolis, in 1910, and had practiced for thirty-seven years at Warsaw. He was a member of the Kosciusko County Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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**Edward C. Tinsley, M.D.,** died January twenty-eighth at Indianapolis, at the age of seventy-seven. He graduated from the Louisville Medical College, in 1897, and practiced in Indianapolis approximately twelve years, at which time he retired from the practice of medicine and moved to San Diego. He returned to Indianapolis a few months prior to his death.

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**Allen Otho Dobbins, M.D.,** of Valparaiso, died recently at the age of seventy-six. He was a graduate of the Illinois Medical College, Chicago, in 1903.

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**Morton F. Wolfe, M.D.,** of New Albany, died February sixth at the age of forty-one. He was a graduate of the University of Louisville School of Medicine, in 1932. Doctor Wolfe had served as Floyd County health officer since 1943, and had served as a captain in the Army from June, 1942, until April, 1943, at which time he received a medical discharge.

# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION

### THE COUNCIL

*January 21, 1945*

The Council of the Indiana State Medical Association convened for its midwinter meeting at 9:40 A.M., Sunday, January 21, 1945, in Parlor B, mezzanine floor, Claypool Hotel, Indianapolis, with Dr. Floyd T. Romberger, of Lafayette, chairman, presiding. Roll call showed the following present:

*Members of the Council:*

First District —I. C. Barclay, Evansville
Second District —H. C. Wadsworth, Washington
Third District —Not represented
Fourth District —Charles F. Overpeck, Greensburg
Fifth District —A. M. Mitchell, Terre Haute
Sixth District —W. U. Kennedy, New Castle
Seventh District —Walter L. Portteus, Franklin
Eighth District —E. H. Clauser, Muncie
Ninth District —Floyd T. Romberger, LaFayette
Tenth District —W. H. Howard, Hammond
Eleventh District —Not represented
Twelfth District —A. Jerome Sparks, Fort Wayne
Thirteenth District—Alfred Ellison, South Bend

*Officers:*

N. K. Forster, Hammond, president 1945
A. F. Weyerbacher, Indianapolis, treasurer
Cleon A. Nafe, Indianapolis, chairman, Executive Committee
C. H. McCaskey, Indianapolis, member, Executive Committee
Albert Stump, Indianapolis, attorney
T. A. Hendricks, executive secretary.

*Legislative Committee:*

Norman M. Beatty, Indianapolis } co-chairmen.
J. William Wright, Indianapolis }

On motion of Dr. Mitchell, seconded by Dr. Sparks, the minutes of the October 3, October 5, and December 10, 1944, meetings of the Council, held at Indianapolis, were approved as printed in the November, 1944, and January, 1945, issues of THE JOURNAL.

The councilors had no reports to make on district activities.

District meetings were reported scheduled as follows for 1945:

Fourth District—May 23, Madison.

Eleventh District—May 16, Logansport.

The chairman asked that the councilors of the other districts notify the headquarters office immediately when the dates of their district meetings are set, in order to avoid conflicts. He announced that the American Medical Association meeting which was scheduled to be held in Philadelphia, June 18 to 22, 1945, had been canceled upon orders from the Office of Defense Transportation.

#### REPORTS OF OFFICERS

*Dr. N. K. Forster*, president 1945: "The past year has been productive of a great deal of activity on the part of our organization. Notable has been the consideration of a prepayment plan for health insurance. For the first time in our history, so far as I know, it was necessary to call a special meeting of the House of Delegates to consider the problem as a single, definite matter. You are familiar with the outcome, and that a new committee was to be appointed by Doctor Oliphant with the help of the Council. A special meeting of your members was called to consider this question and to present suggestions for membership on this committee. Doctor Oliphant, very graciously, asked my suggestions, and I sent him a long list of names. From these and others the following committee has been selected, and we offer it to you for your approval:

1. Dr. W. U. Kennedy, New Castle, chairman (surgery and general practice)
2. First District—Dr. Robert Acre, Evansville (urology)
3. Second District—Dr. C. Philip Fox, Washington (surgery)
4. Third District—Dr. Claude Dollens, Oolitic (general practice)
5. Fourth District—Dr. I. M. Sanders, Greensburg (general practice)
6. Fifth District—Dr. M. C. Topping, Terre Haute (orthopedic surgery)
7. Sixth District—Dr. Joseph L. Allen, Greenfield (general practice)
8. Seventh District—Dr. Marlow W. Manion, Indianapolis (ear, nose and throat)
9. Eighth District—Dr. Bruce Stocking, Muncie (x-ray)
10. Ninth District—Dr. Wemple Dodds, Crawfordsville (x-ray)
11. Tenth District—Dr. Robert Doty, Gary (obstetrics and gynecology)
12. Eleventh District—Dr. G. M. Nie, Huntington (general practice)

*13. Twelfth District—Dr. H. D. Brickley, Bluffton (surgery)

14. Thirteenth District—Dr. F. R. N. Carter, South Bend (urology and general practice)
15. Dr. Robert Masters, Indianapolis (ophthalmology)
16. Dr. Lyman T. Meiks, Indianapolis (pediatrics)
17. Past President—Dr. F. S. Crockett, Lafayette (urology)

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** As Dr. Brickley cannot serve on this committee, Dr. Justin R. Nash, Albion (general practice and dermatology) has been appointed to fill this place.*

*Councilors, North Half*

18. Dr. W. H. Howard, Hammond (general practice)
19. Dr. A. J. Sparks, Fort Wayne (urology)

*Councilors, South Half*

20. Dr. Walter Portteus, Franklin (general practice)
21. Dr. A. P. Hauss, New Albany (general practice)

If this meets with your approval, I will appreciate a motion from some councilor to have this selection named as the Committee on Prepayment of Medical and Surgical Care.

"You are also no doubt aware that the Committee on High School Athletic Activities has been changed to the Committee on Physical Fitness in order to cooperate more fully with the A. M. A. and national committees. In addition, we have appointed a new Committee on Postwar Medical Service to suggest and provide means for helping the readjustment of those of our membership in the armed forces. Another new committee is that on Medical Economics, dealing with such problems as may affect our own economic welfare, such as group insurance questions, collection problems, investment questions or any other factors definitely affecting our daily life in its economic aspects. Finally, the Committee on Public Relations has been replaced by the Council on Medical Service and Public Relations in the hope that we may more actively cooperate with the original Council of the A. M. A. in its activities and to aid in carrying out their recommendations.

"Undoubtedly you will also consider the advisability of holding a convention this year in view of the new directive issued by the O. D. T. Whatever your decision may be, it does not permit for relaxation in any of our activities, and the work that must be done to continue our organization on the high plane it occupies.

"And last, I should like to call your attention to a matter which, I believe, requires correction. For the past twelve years you have had as your Editor of THE JOURNAL, Dr. E. M. Shanklin. I believe that he has served faithfully and well, and has brought THE JOURNAL to a standard of excellence unequaled in the country. During all this time his remuneration has been the same, $100.00 a month, less the withholding taxes. This, in spite of the fact that THE JOURNAL has consistently made money for the organization until recently. His assistant, Miss Rokke, has also been a tireless and faithful worker and deserving of a definite recognition. Therefore, when you come to the question of signing the new contract with the Editor, I would like to suggest that you give consideration to the proposition that he be given an increase of $100.00 a month, making his remuneration $200.00 a month. Also that Miss Rokke be given an increase of $10.00 a week. Now, I realize that at the present time THE JOURNAL shows a budget deficit, but we are increasing our advertising rates and subscription rates, and I feel that this recognition is overdue, even if we have to go into our surplus to meet it or to increase the budget allowance.

"During the coming year, I hope to have your help and cooperation in deciding the questions to come before our organization. I realize my own shortcomings and the need for your assistance. The decisions to be made and the problems to come before us will, undoubtedly, be many and great—perhaps influencing to a considerable extent our future in the practice of medicine. Since we are all involved, I am confident of your help, and I assure you now of my deep appreciation."

Dr. Wadsworth made the motion that the committee named by Dr. Forster be accepted as the committee for the preparation of documents or forms for a prepayment medical care plan. Motion seconded by Dr. Portteus, and carried.

Motion was made by Dr. Mitchell, seconded by Dr. Barclay, and carried, that an announcement of the membership of the committee on health insurance should be made in the newspapers.

On the motion of Dr. Kennedy, seconded by Dr. Ellison, the salary of the Editor of THE JOURNAL was increased to $150.00 per month, beginning with January, 1945.

Upon the motion of Dr. Mitchell, seconded by Dr. Wadsworth, the matter of an increase in Miss Rokke's salary was referred to the Executive Committee.

*Dr. A. F. Weyerbacher*, treasurer, presented the following report, which was compiled by George S. Olive and Company, certified public accountants:

### TREASURER'S REPORT

January 16, 1945.

The Council,
Indiana State Medical Association,
Indianapolis, Indiana.
Gentlemen:

We have examined the cash records of your Association for the year ended December 31, 1944. This examination was undertaken for the purpose of determining and verifying the cash transactions for the year, and of verifying the assets and liabilities at the close of the year, as recorded on the records.

The results of our examination are presented in this report, which includes: (1) text of comments; (2) statement of assets of all funds at December 31, 1944; and (3) statements of receipts and disbursements of all funds, year ended December 31, 1944. A list of the statements is presented on the first page following this text.

### GENERAL COMMENT

In Exhibit A is presented an analysis of the decrease in assets of the Association for the year ended December 31, 1944, showing in summary form the sources from which this decrease was derived.

The decrease of $8,053.90 is attributable to: (1) an excess of operating cash disbursements over operating cash receipts of the General Fund in the amount of $6,665.90; (2) an excess of operating disbursements over operating receipts of THE JOURNAL of the Indiana State Medical Association in the amount of $1,491.50; offset by (3) an increase in assets of the Medical Defense Fund of $103.50.

During the period under review, funds were transferred from the Medical Defense fund in the amount of $5,000. THE JOURNAL of The Indiana State Medical Association received $3,000, as may be noted in Exhibit D, and the Association received $2,000, as is set forth in Exhibit C. These amounts so transferred are to be considered as loans.

Details of the assets of all funds are presented in Exhibit B. There were no recorded liabilities at December 31, 1944, and the assets shown represent the surplus of each fund at that date. We have examined the securities of the Association, and confirmed bank balances by direct correspondence with the depositories.

Details of the cash receipts and disbursements of the General Fund, of THE JOURNAL of The Indiana State Medical Association, and of the Medical Defense Fund are presented in Exhibits C, D, and E.

Yours very truly,

GEO. S. OLIVE & CO.

*Certified Public Accountants.*

### Indiana State Medical Association

LIST OF STATEMENTS CONTAINED IN REPORT ON EXAMINATION OF CASH RECORDS, YEAR ENDED DECEMBER 31, 1944

Exhibit A—Analysis of decrease in assets, all funds, year ended December 31, 1944.

Exhibit B—Statement of assets, all funds, at December 31, 1944.

Exhibit C—Comparative statement of cash receipts and disbursements, years ended December 31, 1943, and December 31, 1944.

Exhibit D—Statement of cash receipts and disbursements of THE JOURNAL of The Indiana State Medical Association, year ended December 31, 1944.

Exhibit E—Statement of cash receipts and disbursements of the Medical Defense Fund, year ended December 31, 1944.

## EXHIBIT A

### Indiana State Medical Association

ANALYSIS OF DECREASE IN ASSETS, ALL FUNDS, YEAR ENDED DECEMBER 31, 1944

| | | | |
|---|---|---|---|
| **TOTAL ASSETS, DECEMBER 31, 1944—Exhibit B** | | $45,091.95 | |
| **TOTAL ASSETS, DECEMBER 31, 1943** | | 53,145.85 | |
| **NET DECREASE** | | | **$ 8,053.90** |
| Arising from the following sources: | | | |
| Excess of operating cash disbursements over operating cash receipts, General Fund, year ended December 31, 1944: | | | |
| Receipts—Exhibit C | $34,086.77 | | |
| Disbursements—Exhibit C | 38,752.67 | | |
| | | **$4,665.90** | |
| Less: Receipts arising from loan from Medical Defense Fund | | **2,000.00** | |
| | | **$6,665.90** | |
| Excess of operating disbursements over operating receipts, THE JOURNAL of The Indiana State Medical Association, year ended December 31, 1944: | | | |
| Receipts—Exhibit D | $25,485.16 | | |
| Disbursements—Exhibit D | 23,976.66 | | |
| | | 1,508.50 | |
| Less: Receipts arising from loan from Medical Defense Fund | | **3,000.00** | |
| | | **1,491.50** | |
| Excess of operating receipts over operating disbursements, Medical Defense Fund, year ended December 31, 1944: | | | |
| Receipts—Exhibit E | $ 2,788.75 | | |
| Disbursements—Exhibit E | 7,685.25 | | |
| | | **4,896.50** | |
| Add: Disbursements arising from loans to The Indiana State Medical Association and THE JOURNAL of The Indiana State Medical Association | | 5,000.00 | |
| | | 103.50 | |
| **Total Net Decrease** | | | **$ 8,053.90** |

## EXHIBIT B

STATEMENT OF ASSETS, ALL FUNDS, AT DECEMBER 31, 1944

| | | | |
|---|---|---|---|
| **General Fund:** | | | |
| Cash on deposit—Exhibit C | | $ 465.91 | |
| Petty cash fund | | 200.00 | |
| Investments: | | | |
| Marion County Flood Prevention bonds | $3,000.00 | | |
| Indianapolis City Hospital bonds | 5,000.00 | | |
| United States Treasury bonds | 13,000.00 | | |
| United States Savings bonds | 5,000.00 | | |
| | | 26,000.00 | |
| | | 26,665.91 | |
| Less: Loans payable to Medical Defense Fund | | 2,000.00 | |
| Total General Fund | | | $24,665.91 |
| **The Journal of The Indiana State Medical Association:** | | | |
| Cash on deposit—Exhibit D | | $ 2,894.32 | |
| Less: Loans payable to Medical Defense Fund | | 3,000.00 | |
| Total JOURNAL deficit | | | **105.68** |
| **Medical Defense Fund:** | | | |
| Cash on deposit—Exhibit E | | 531.72 | |
| Investments: | | | |
| Marion County Flood Prevention bonds | $ 2,000.00 | | |
| United States Treasury bonds | 5,000.00 | | |

| | | | |
|---|---|---|---|
| United States Savings bonds | 5,000.00 | | |
| United States Baby bonds | 3,000.00 | | |
| | | 15,000.00 | |
| | | 15,531.72 | |
| Due from General Fund | 2,000.00 | | |
| Due from THE JOURNAL of The Indiana State Medical Association | 3,000.00 | | |
| | | 5,000.00 | |
| | | | 20,531.72 |
| **Total Assets, All Funds—Exhibit A** | | | **$45,091.95** |

## EXHIBIT C

COMPARATIVE STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS, YEARS ENDED DECEMBER 31, 1944, AND DECEMBER 31, 1943

| | *Year Ended December 31, 1944* | *Year Ended December 31, 1943* | Increase **Decrease** |
|---|---|---|---|
| CASH BALANCE AT BEGINNING OF YEAR | $ 5,131.81 | $10,975.14 | **$ 5,843.33** |
| **Receipts:** | | | |
| Membership dues | 23,288.50 | 23,132.00 | 156.50 |
| Income from exhibits | 7,575.00 | 5,455.00 | 2,120.00 |
| Petty cash refund—contra | | 300.00 | **300.00** |
| Miscellaneous refunds | 3.30 | 45.50 | **42.20** |
| Beachton Court Liquidation Trust distribution | | 35.80 | **35.80** |
| Interest income: | | | |
| United States Treasury bonds | 368.75 | 368.75 | |
| United States Savings bonds | 125.00 | 87.50 | 37.50 |
| Indianapolis, Indiana, City Hospital bonds | 200.00 | 200.00 | |
| Marion County, Indiana, Flood Prevention bonds | 127.50 | 127.50 | |
| Instructional courses—annual session | 145.00 | 169.25 | **24.25** |
| Refund on convention expense | 193.72 | 156.67 | 37.05 |
| Industrial health conference | 60.00 | | 60.00 |
| Funds transferred from Medical Defense Fund | 2,000.00 | | 2,000.00 |
| | $34,086.77 | $30,077.97 | $ 4,008.80 |
| BEGINNING BALANCE PLUS CASH RECEIPTS | $39,218.58 | $41,053.11 | **$ 1,834.53** |
| **Disbursements:** | | | |
| Transfer of applicable portion of dues to THE JOURNAL of The Indiana State Medical Association — Exhibit D | $ 6,768.00 | $ 6,638.00 | $ 130.00 |
| Medical Defense Fund — Exhibit E | 2,460.00 | 2,414.25 | 45.75 |
| Headquarters office expense | 12,064.95 | 10,608.60 | 1,456.35 |
| Publicity committee | 2,051.00 | 394.96 | 1,656.04 |
| Public policy | 283.27 | 1,973.40 | **1,690.13** |
| Council | 6,241.36 | 6,153.25 | 88.11 |
| Officers | 313.39 | 521.20 | **207.81** |
| Rent | 500.00 | 500.00 | |
| Annual session | 4,957.20 | 4,049.86 | 907.34 |
| Miscellaneous committees | 2,882.11 | 1,996.07 | 886.04 |
| Federal old age benefit tax | 76.39 | 64.21 | 12.18 |
| Military dues refunds | 30.00 | 282.50 | **252.50** |
| Petty cash refund—contra | | 300.00 | **300.00** |
| Other refunds | 25.00 | 25.00 | |
| Instructional course expense | 100.00 | | 100.00 |
| | $38,752.67 | $35,921.30 | $ 2,831.37 |
| **Cash Balance at End of Year** | $ 465.91 | $ 5,131.81 | **$ 4,665.90** |

*(Exhibit B)*

## EXHIBIT D

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS, YEAR ENDED DECEMBER 31, 1944

### THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION

| | | |
|---|---|---|
| BALANCE, JANUARY 1, 1944 | | $ 1,385.82 |
| **Receipts:** | | |
| Subscriptions—members—Exhibit C | $ 6,768.00 | |
| Subscriptions—non-members | 265.50 | |
| Advertising | 15,207.55 | |
| Collection on accounts receivable | 140.50 | |
| Single copy sales | 26.20 | |
| Electrotypes | 77.41 | |
| Funds transferred from Medical Defense Fund | 3,000.00 | |
| Total receipts—Exhibit A | | 25,485.16 |
| | | 26,870.98 |
| **Disbursements:** | | |
| Editorial and management salaries | 9,628.31 | |
| Printing | 10,682.64 | |
| Office postage | 210.00 | |
| Journal postage | 552.97 | |
| Press clippings | 54.91 | |
| Electrotypes | 782.32 | |
| Telephone and telegraph | 172.80 | |
| Office rent and electricity | 540.99 | |
| Office supplies | 634.31 | |
| Advertising commissions | 440.12 | |
| Federal O.A.B. tax | 55.49 | |
| Expenses—editor and editorial board | 140.93 | |
| Sundry | 80.87 | |
| Total disbursements—Exhibit A | | 23,976.66 |
| **Balance, December 31, 1944—Exhibit B** | | **$ 2,834.32** |

## EXHIBIT E

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS, YEAR ENDED DECEMBER 31, 1944

### MEDICAL DEFENSE FUND

| | | | |
|---|---|---|---|
| BALANCE, JANUARY 1, 1944 | | | $ 5,428.22 |
| **Receipts:** | | | |
| Transfer of applicable portion of dues from the General Fund—Exhibit C | $ 2,460.00 | | |
| Interest income: | | | |
| U. S. Treasury bonds | $156.25 | | |
| U. S. Savings bonds | 87.50 | | |
| Marion County Flood Prevention bonds | 85.00 | | |
| | | 328.75 | |
| Total receipts—Exhibit A | | | 2,788.75 |
| | | | 8,216.97 |
| **Disbursements:** | | | |
| Attorney's fee | | 1,800.00 | |
| Malpractice fees | | 850.00 | |

| | | |
|---|---|---|
| Treasurer's bond | 15.00 | |
| Printing | 20.25 | |
| Funds transferred to General Fund | 2,000.00 | |
| Funds transferred to THE JOURNAL of The Indiana State Medical Association | 3,000.00 | |
| Total disbursements | | 7,685.25 |
| **Balance, December 31, 1944—Exhibit B** | | **$ 531.72** |

The treasurer's report was adopted upon the motion of Dr. Mitchell, seconded by Dr. Wadsworth.

The executive secretary read a brief, informal report from Dr. E. M. Shanklin, editor of THE JOURNAL, as he was unable to attend the meeting because of illness.

*Dr. Cleon A. Nafe*, chairman of the Executive Committee, discussed the following matters with the Council:

(1) *Public Relations Council, A. M. A.* Following the approval of the Council at its special meeting on December 10, that Thomas A. Hendricks, executive secretary, be available part time as secretary of the Council on Medical Service and Public Relations of the American Medical Association, conferences were held by Mr. Hendricks with Dr. Olin West, secretary of the A. M. A. This matter is to be referred to the Board of Trustees of the A. M. A., which is to meet sometime during the month of February.

(2) *Group Malpractice Insurance.* Dr. Nafe reported that to date the St. Paul Mercury Indemnity Company has written 275 policies for Indiana physicians, and others are being written as individual contracts expire. "The Executive Committee feels that their coverage is complete, while a good many of the other companies have a considerable limitation. Mr. Crane notes that a considerable number of doctors in Indiana do not carry malpractice insurance."

**SUGGESTIONS AND PROPOSALS FOR 1945 (96TH) ANNUAL SESSION AT FRENCH LICK SPRINGS HOTEL**

1. *Dates set* by the Executive Committee, Tuesday, Wednesday, and Thursday, October 2, 3, and 4, 1945, approved by the Council.

2. *ODT ruling.* Dr. Barclay moved that the Executive Committee be authorized to determine from the Office of Defense Transportation whether or not the annual session can be held. Motion seconded by Drs. Mitchell and Wadsworth, and carried.

3. *Instructional courses.* Upon the motion of Dr. Barclay, the Council unanimously approved having instructional courses at the 1945 session, and Dr. Mitchell moved that these courses be put on in the same manner as they have been heretofore. Motion seconded by Dr. Barclay, and carried.

4. *Stag party.* It was taken by consent that arrangements for the smoker and stag party should be left to the Executive Committee.

5. *Type of scientific meetings.* Dr. Wadsworth made the motion that the meetings be general in character, and so arranged that each section will be represented by a speaker in its specialty. Motion seconded by Dr. Barclay, and carried.

6. *Thursday morning scientific meeting.* It was taken by consent that no Thursday morning scientific meeting should be held.

7. *Preliminary program.* The preliminary program, including the foregoing suggestions, is as follows:

*Monday, October 1, 1945*

Meeting of health officers.

*Tuesday, October 2, 1945*

Morning —Registration
Instructional courses
Commercial exhibit
Afternoon—Council meeting
Meeting of House of Delegates
Instructional courses
Evening —Smoker and stag party
Dinner for women physicians

*Wednesday, October 3, 1945*

Morning —General scientific meeting
Noon —Class and fraternity get-togethers and luncheons
Afternoon—General scientific meeting
Evening —Annual dinner

*Thursday, October 4, 1945*

Morning —Final meeting of House of Delegates
Final Council meeting
Adjournment

8. *Army participation in meeting.* The suggestion was made that the Fifth Service Command, with headquarters at Columbus, Ohio, might be invited to participate in the convention program. If this is found to be infeasible, it was suggested that individual military groups in Indiana and adjoining states, such as the groups at Vincennes, Burns City, Seymour, Evansville (Breckenridge), Camp Knox, Peru, et cetera, might be asked to take part in the program and the scientific exhibit. It was taken by consent that the executive secretary should proceed along these lines and report to the Executive Committee in the ensuing months.

9. *Convention details.* It was taken by consent that the handling of details for the meeting should be referred to the Executive Committee.

10. *Professional medical stenographers.* It was taken by consent that professional medical stenographers should be employed.

When you buy War Bonds you speed the winning of the war.

## MEMBERSHIP PROBLEMS

1. *Membership report.*

### MEMBERSHIP REPORT

### Indiana State Medical Association

December 31, 1944

| County Society | No. M.D.'s in County* | Members Dec. 31, 1944 | Members Dec. 31, 1943 | Loss— Gain | Eligible | Non-Members | New Members | Removed and Retired | Deceased | Ineligible | No. M.D.'s in Service*# |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **1st District** | | | | | | | | | | | |
| Posey | 15 | 13 | 12 | 1 | | | 2 | 2 | 1 | | 4 |
| Vanderburgh | 199 | 158 | 151 | 7 | 26 | | 5 | 15 | 3 | 4 | 50 |
| Warrick | 17 | 12 | 13 | —1 | | | | 5 | | | 5 |
| Spencer | 16 | 11 | 11 | | 2 | | | 2 | | 1 | 3 |
| Perry | 12 | 10 | 9 | —1 | 1 | | | | | 1 | |
| Gibson | 26 | 25 | 26 | —1 | | | | 1 | 2 | | 7 |
| Pike | 12 | 8 | 11 | —3 | 3 | | | 1 | | | |
| Total | 297 | 237 | 233 | 4 | 32 | 7 | 26 | 6 | 6 | | 69 |
| **2nd District** | | | | | | | | | | | |
| Knox | 51 | 41 | 41 | | 4 | | | 6 | 1 | 1 | 4 |
| Daviess-Martin | 30 | 24 | 26 | —2 | 4 | | | 1 | 1 | | 8 |
| Sullivan | 27 | 22 | 21 | 1 | 1 | 2 | | 6 | 2 | | 1 |
| Greene | 23 | 19 | 19 | | 3 | | | | 1 | | 8 |
| Owen | 11 | 11 | 11 | | | | | | | | 3 |
| Monroe | 37 | 34 | 37 | —3 | 1 | 1 | | 1 | 2 | | 13 |
| Total | 179 | 151 | 155 | —4 | 13 | 3 | | 14 | 7 | 1 | 37 |
| **3rd District** | | | | | | | | | | | |
| Lawrence | 30 | 21 | 23 | —2 | 1 | | | 4 | 4 | | 7 |
| *Orange | 13 | 13 | 13 | | | | | | | | 2 |
| Crawford | 7 | 6 | 6 | | | | | 1 | | | 1 |
| Washington | 12 | 11 | 11 | | | | | | 1 | | 4 |
| Scott | 8 | 5 | 5 | | 1 | | | 2 | | | |
| Clark | 39 | 21 | 18 | 3 | 15 | 2 | | 2 | | 1 | 5 |
| *Floyd | 44 | 38 | 38 | | 3 | 1 | | 1 | | 2 | 11 |
| Harrison | 8 | 8 | 8 | | | | | | | | 1 |
| Dubois | 18 | 17 | 19 | —2 | 1 | | | | | | 4 |
| Total | 179 | 140 | 141 | —1 | 21 | 3 | | 10 | 5 | 3 | 35 |
| **4th District** | | | | | | | | | | | |
| Brown | 1 | | | | | | | | | | |
| *Bartholomew | 37 | 30 | 29 | 1 | 2 | | | 3 | 2 | 3 | 8 |
| Decatur | 18 | 16 | 17 | —1 | | | | 2 | | | 4 |
| Jackson | 19 | 17 | 17 | | 1 | | | 1 | | | 3 |
| *Jennings | 12 | 12 | 12 | | | | | 1 | 1 | | 3 |
| *Ripley | 14 | 13 | 13 | | 1 | | | | | | 3 |
| Jefferson | 22 | 17 | 19 | —2 | 2 | | | 3 | 1 | | 2 |
| Switzerland | 8 | 5 | 7 | —2 | 2 | | | 1 | 1 | | |
| *Dearborn-Ohio | 24 | 19 | 19 | | 1 | | | | 3 | 2 | 7 |
| Total | 155 | 129 | 133 | —4 | 9 | | | 11 | 8 | 5 | 30 |
| **5th District** | | | | | | | | | | | |
| Parke-Vermillion | 37 | 29 | 27 | 2 | 4 | 2 | | 5 | 2 | 1 | 4 |
| *Putnam | 21 | 19 | 17 | 2 | | 2 | | | 1 | 2 | 5 |
| Vigo | 119 | 103 | 106 | —3 | 5 | 2 | | 6 | 6 | 6 | 22 |
| Clay | 17 | 16 | 16 | | | 1 | | 1 | | | 3 |
| Total | 194 | 167 | 166 | 1 | 9 | 7 | | 12 | 9 | 9 | 34 |
| **6th District** | | | | | | | | | | | |
| Hancock | 28 | 26 | 24 | 2 | | | 2 | 1 | 1 | | 10 |
| *Henry | 39 | 37 | 39 | —2 | 1 | | | 1 | | 1 | 15 |
| *Wayne-Union | 74 | 62 | 59 | 3 | 5 | | 2 | 5 | 1 | 3 | 18 |
| Rush | 18 | 14 | 15 | —1 | 1 | | | 2 | 2 | 1 | 2 |
| Fayette-Franklin | 23 | 19 | 19 | | | | | 1 | 2 | 2 | 3 |
| Shelby | 35 | 28 | 27 | 1 | 1 | | 2 | 4 | 4 | | 9 |
| Total | 217 | 186 | 183 | 3 | 8 | | 6 | 14 | 10 | 7 | 57 |
| **7th District** | | | | | | | | | | | |
| Hendricks | 19 | 18 | 17 | 1 | | | 1 | 1 | | 1 | 4 |
| *Marion | 888 | 726 | 700 | 26 | 122 | | 35 | 37 | 8 | 21 | 232 |
| *Morgan | 32 | 22 | 21 | 1 | 5 | | 1 | 4 | 1 | 1 | 5 |
| *Johnson | 19 | 15 | 15 | | 4 | | | 1 | | | 3 |
| Total | 958 | 781 | 753 | 28 | 131 | | 37 | 43 | 9 | 23 | 244 |
| **8th District** | | | | | | | | | | | |
| *Madison | 97 | 85 | 83 | 2 | 7 | | 1 | 6 | 2 | 2 | 26 |
| *Delaware-Blackford | 101 | 84 | 80 | 4 | 11 | | 2 | 4 | 3 | 3 | 29 |
| Jay | 26 | 22 | 21 | 1 | 2 | | 1 | 3 | 1 | | 8 |
| Randolph | 25 | 23 | 23 | | 1 | | | 2 | | | 5 |
| Total | 249 | 214 | 207 | 7 | 21 | | 4 | 15 | 6 | 5 | 68 |
| **9th District** | | | | | | | | | | | |
| Benton | 11 | 10 | 11 | —1 | | | | 1 | | 1 | 1 |
| Fountain-Warren | 21 | 18 | 19 | —1 | 3 | | 1 | 2 | 1 | | 3 |
| *Tippecanoe | 94 | 89 | 87 | 2 | 3 | | 3 | 3 | 1 | | 33 |
| *Montgomery | 35 | 30 | 27 | 3 | 2 | | | 4 | | | 9 |
| Clinton | 24 | 22 | 22 | | | | | 2 | | | 7 |
| Tipton | 15 | 11 | 10 | 1 | 3 | | 2 | 1 | 1 | | 2 |
| Boone | 25 | 21 | 21 | | 4 | | 1 | | 1 | | 6 |
| Hamilton | 27 | 21 | 20 | 1 | 3 | | 1 | 2 | | 1 | 5 |
| White | 8 | 4 | 4 | | 4 | | | | | | |
| Total | 260 | 226 | 221 | 5 | 22 | | 8 | 15 | 4 | 2 | 66 |
| **10th District** | | | | | | | | | | | |
| Lake | 293 | 247 | 251 | —4 | 36 | | 4 | 9 | 3 | 4 | 61 |
| Porter | 30 | 28 | 29 | —1 | 1 | | 1 | 3 | | | 9 |
| Jasper-Newton | 20 | 16 | 17 | —1 | 3 | | | 1 | | | 4 |
| Total | 343 | 291 | 297 | —6 | 40 | | 5 | 13 | 3 | 4 | 74 |
| **11th District** | | | | | | | | | | | |
| Carroll | 14 | 13 | 13 | | | | | 1 | 1 | | 5 |
| *Cass | 50 | 39 | 38 | 1 | 6 | | 1 | 4 | 1 | 1 | 11 |
| *Miami | 27 | 22 | 21 | 1 | 3 | | | 1 | 1 | 1 | 4 |
| *Wabash | 31 | 25 | 25 | | 1 | | | 5 | 1 | | 7 |
| Huntington | 29 | 27 | 28 | —1 | | | | 1 | 1 | 1 | 8 |
| Howard | 45 | 38 | 38 | | 1 | | 1 | 4 | 2 | 2 | 14 |
| Grant | 62 | 49 | 50 | —1 | 8 | | 1 | 5 | 1 | 2 | 12 |
| Total | 258 | 213 | 213 | | 19 | | 3 | 21 | 8 | 7 | 61 |
| **12th District** | | | | | | | | | | | |
| LaGrange | 5 | 5 | 7 | —2 | | | | | | | |
| Steuben | 20 | 12 | 10 | 2 | 6 | | | 2 | 2 | | 3 |
| *Noble | 26 | 25 | 26 | —1 | | | | | 1 | | 5 |
| DeKalb | 26 | 22 | 21 | 1 | 3 | | 2 | 1 | | | 5 |
| Whitley | 16 | 12 | 12 | | | | | 3 | | 3 | 3 |
| Allen | 201 | 175 | 172 | 3 | 13 | | 9 | 7 | | 9 | 66 |
| *Wells | 25 | 21 | 21 | | 3 | | | 1 | 2 | | 5 |
| *Adams | 23 | 21 | 20 | 1 | | | 1 | | | 2 | 5 |
| Total | 342 | 293 | 289 | 4 | 25 | | 12 | 14 | 5 | 14 | 92 |

| County Society | No. M.D.'s in County* | Members Dec. 31, 1944 | Members Dec. 31, 1943 | Loss—Gain | Eligible Non-Members | New Members | Removed and Retired | Deceased | Ineligible | No. M.D.'s in Service** |
|---|---|---|---|---|---|---|---|---|---|---|
| **13th District** | | | | | | | | | | |
| LaPorte | 79 | 67 | 60 | 7 | 8 | 6 | 5 | 2 | | 13 |
| *St. Joseph | 193 | 166 | 157 | 9 | 14 | 7 | 10 | 1 | 5 | 51 |
| *Elkhart | 87 | 73 | 73 | | 6 | 3 | 8 | 2 | 1 | 21 |
| Starke | 4 | 4 | 5 | —1 | | | | | | 1 |
| Pulaski | 8 | 8 | 8 | | | | | | | 2 |
| Fulton | 16 | 12 | 12 | | 2 | | 2 | | | 3 |
| Marshall | 29 | 24 | 25 | —1 | | | 3 | 1 | 3 | 7 |
| Kosciusko | 22 | 17 | 15 | 2 | 2 | | 2 | 1 | | 4 |
| Total | 438 | 371 | 355 | 16 | 32 | 16 | 30 | 7 | 9 | 102 |
| **Summary by Districts** | | | | | | | | | | |
| 1st District | 297 | 237 | 233 | 4 | 32 | 7 | 26 | 6 | 6 | 69 |
| 2nd District | 179 | 151 | 155 | —4 | 13 | 3 | 14 | 7 | 1 | 37 |
| 3rd District | 179 | 140 | 141 | —1 | 21 | 3 | 10 | 5 | 3 | 35 |
| 4th District | 155 | 129 | 133 | —4 | 9 | | 11 | 8 | 5 | 30 |
| 5th District | 194 | 167 | 166 | 1 | 9 | 7 | 12 | 9 | 9 | 34 |
| 6th District | 217 | 186 | 183 | 3 | 8 | 6 | 14 | 10 | 7 | 57 |
| 7th District | 958 | 781 | 753 | 28 | 131 | 37 | 43 | 9 | 23 | 244 |
| 8th District | 249 | 214 | 207 | 7 | 21 | 4 | 15 | 6 | 5 | 68 |
| 9th District | 260 | 226 | 221 | 5 | 22 | 8 | 15 | 4 | 2 | 66 |
| 10th District | 343 | 291 | 297 | —6 | 40 | 5 | 13 | 3 | 4 | 74 |
| 11th District | 258 | 213 | 213 | | 19 | 3 | 21 | 8 | 7 | 61 |
| 12th District | 342 | 293 | 289 | 4 | 25 | 12 | 14 | 5 | 14 | 92 |
| 13th District | 438 | 371 | 355 | 16 | 32 | 16 | 30 | 7 | 9 | 102 |
| Total | 4069 | 3399 | 3346 | 53 | 382 | 111 | 238 | 87 | 95 | 969 |

** Physicians are listed in the counties in which they hold membership; not in the counties in which they reside.*

*** Military service—969 Indiana physicians who are in service are members of the state association. In addition, 291 Indiana physicians are in service who are not association members, making a total of 1,260 in service. Some of these physicians have not practiced in the state and therefore are not members, and others have not been reported as members by their county society secretary.*

2. *Allen County membership problem.* Dr. Sparks discussed the problem which the Fort Wayne (Allen County) Medical Society has encountered due to the passing of a resolution which prohibits admission of new members to the society for the duration of the war. This matter was brought before the Council at its special meeting on December 10, 1944, at which time Dr. Sparks' attention was called to Section 4, Chapter X, of the By-Laws, which states that "Each county society shall be judge of the qualifications of its own members." The Council took no further action on this matter at this time.

### ECONOMIC AND ORGANIZATION MATTERS

1. *JOURNAL advertising.* It was taken by consent that Indiana Brewers Association institutional advertisements should be accepted.

2. *Inter-Professional Health Council.* Dr. F. S. Crockett of Lafayette was reappointed chairman, and Dr. A. M. Mitchell, Terre Haute, was made a member of the Committee on Indiana Inter-Professional Health Council of the Indiana State Medical Association.

### NEW BUSINESS

1. *Contract with Editor of THE JOURNAL,* prepared by the attorney of the association, signed by Dr. Romberger, chairman of the Council.

2. *Nominations for Editorial Board.*

Dr. Portteus nominated Dr. James F. Balch, Indianapolis.

Dr. Ellison nominated Dr. F. R. N. Carter, South Bend.

Dr. Sparks nominated Dr. E. L. Bulson, Fort Wayne.

3. *Ohio River Valley Water Sanitation Compact.* Resolution passed by the Ohio State Medical Association to bring pressure on the Pennsylvania and Virginia State Medical Associations to lend their support to approval of the Ohio River Valley Water Sanitation Compact, by the legislatures of Pennsylvania and Virginia, was brought to the attention of the Council. Dr. Mitchell made the motion that "The Council of the Indiana State Medical Association favor the resolution and lend its support thereto." Motion seconded by Dr. Howard, and carried.

### LEGISLATIVE MATTERS

*Dr. N. M. Beatty,* co-chairman of the Committee on Public Policy and Legislation, discussed the various bills that have been or are to be introduced in the 1945 session of the Legislature, asking for instructions in particular as to procedure on S. B. 176, the Osteopathic Bill. The motion made by Dr. Ellison and seconded by Dr. Wadsworth to oppose this bill was lost, upon vote of the Council.

### ELECTIONS FOR 1945

1. *Executive Committee members.* Upon the motion of Dr. Portteus, seconded by Dr. Barclay, Dr. Cleon A. Nafe and Dr. Carl H. McCaskey were re-elected members of the Executive Committee for 1945.

2. *Chairman of the Council.* Upon the motion of Dr. Howard, seconded by Dr. Wadsworth, Dr. F. T. Romberger was re-elected chairman of the Council for 1945.

### LUNCHEON

*Industrial Tuberculosis Survey.* Mr. Murray Auerbach, secretary, and members of the Board of Directors of the Indiana Tuberculosis Association appeared before the Council to explain the use to which a mobile tuberculosis screening unit would be put if the purchase and use of such a unit were approved by the Council. Points brought out in the discussion of this matter follow:

(1) This is a method of finding early tuberculosis.

(2) The tuberculosis association has been operating a unit on a contract for several months. It has x-rayed about 60,000 persons and has 40,000 on the itinerary scheduled.

*(Continued on page xxv)*

*(Continued from page 120)*

(3) The unit can be bought jointly by the Indiana Tuberculosis Association and the Indiana State Board of Health, or it can be purchased by the tuberculosis association alone. The tuberculosis association would like to have the State Board of Health participate in this in some way. The State Board of Health has not agreed to anything as yet. Dr. Rice is for it, but he says that he will not do anything that the state medical association disapproves.

(4) In some localities there is a charge for this service. In some places industry pays all. In other places industry and the association split the costs. In some instances the individual pays part of the expense.

(5) One of the reasons for the Indiana Tuberculosis Association buying a unit is to make these examinations a non-profit affair.

(6) The Indiana Roentgen Society has gone on record favoring the purchase of a unit.

(7) The reports are handled through the tuberculosis association. Contact is with the doctor and the state tuberculosis association.

(8) The government has allocated $350,000 to Indiana for tuberculosis work.

(9) The unit is not forced on any county. The local tuberculosis association asks the approval of the county medical society before the Indiana Tuberculosis Association will go into the county with a unit.

Dr. Portteus made the motion that the Council go on record as being in favor of this proposition. The Council approved the purchase and operation of this unit on a standing vote.

There being no further business, the meeting was adjourned.

THOMAS A. HENDRICKS,
*Executive Secretary.*

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## THE COUNCIL

### Special Meeting, Indianapolis

*February 11, 1945*

The Council, the Executive Committee, and the Committee on Public Policy and Legislation of the Indiana State Medical Association convened in the Harrison Room of the Columbia Club, Indianapolis, Sunday, February 11, 1945, for a special meeting, called to consider matters pending in the Legislature, which concern the medical profession. The meeting was called to order at 1:30 P. M. by Dr. Floyd T. Romberger, chairman. The following were present:

*Members of the Council:*

| | |
|---|---|
| Third District | —A. P. Hauss, New Albany |
| Fifth District | —A. M. Mitchell, Terre Haute |
| Seventh District | —Walter L. Portteus, Franklin |
| Eighth District | —E. H. Clauser, Muncie |
| Ninth District | —Floyd T. Romberger, Lafayette |
| Tenth District | —William H. Howard, Hammond |
| Eleventh District | —C. S. Black, Warren |

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Twelfth District —A. Jerome Sparks, Fort Wayne
Thirteenth District—Alfred Ellison, South Bend

*Executive Committee:*

C. A. Nafe, Indianapolis, chairman
C. H. McCaskey, Indianapolis
J. T. Oliphant, Farmersburg, president 1944
N. K. Forster, Hammond, president 1945
J. E. Ferrell, Fortville, president-elect
A. F. Weyerbacher, Indianapolis, treasurer
Albert Stump, Indianapolis, attorney
T. A. Hendricks, executive secretary

*Committee on Public Policy and Legislation:*

Norman M. Beatty, Indianapolis } co-chairmen
J. William Wright, Indianapolis }
George Daniels, Marion
John Hewitt, Indianapolis
Walter F. Kelly, Indianapolis

*Indiana State Board of Medical Registration and Examination:*

Will C. Moore, Muncie, secretary
Paul R. Tindall, Shelbyville

*Indiana State Board of Health:*

Thurman B. Rice, Indianapolis, secretary
F. R. N. Carter, South Bend, county health officer

Dr. Beatty reviewed pending legislation which concerns the medical profession, stating that the Legislative Committee never has felt that it is the function of the committee to make decisions, but that it should merely carry out the wishes of the state medical association.

The following actions were taken on the various bills which were discussed:

*S. B. 3*, which would allow graduates of medicine who are in military service to be licensed without taking the state board examination. It was taken by consent that the Legislative Committee should use its own judgment in contacting the proper parties or in sending out messages in regard to this bill.

*H. B. 467*, which would exempt chiropractors from examination on application for license after leaving the armed services. It was taken by consent that everything possible be done to defeat this bill.

*H. B. 176*, osteopathic bill. Dr. Ellison made the motion that the Council go on record as opposing this bill. Motion seconded by Dr. Sparks, and carried.

*H. B. 390*, hospital Council measure. Bill approved with amendments to make clear the definition of a "hospital." Motion made by Dr. Howard, seconded, and carried.

*H. B. 411*, which would amend law regulating admission of patients to Riley Hospital, providing for admission of part-pay patients. Dr. Howard moved that the Council not support this bill. Motion seconded by Dr. Portteus, and carried.

*H. B. 129*, which would permit physicians to be appointed to hospital boards. The law governing the membership on hospital boards as it now stands is unconstitutional because it fosters class legislation; it permits anyone but a physician to belong to these boards. It was reported to the Council that the Clay County Medical Society intends to make a test case to have that law declared unconstitutional, if *H. B. 129* fails to pass. It was taken by consent that the Council approved of this action.

Dr. Carter appeared before the Council and discussed public health legislation, and as a result a meeting of the health officers of Indiana is to be called by Dr. Rice, for Wednesday, February 14.

No further business appearing, the meeting adjourned at 4:40 P. M.

THOMAS A. HENDRICKS,
*Executive Secretary.*

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## LOCAL SOCIETY REPORTS

### 100% IN PAYMENT OF 1945 DUES

CLINTON COUNTY
FULTON COUNTY
HANCOCK COUNTY
JACKSON COUNTY
POSEY COUNTY
RUSH COUNTY

### COUNTY MEDICAL SOCIETY OFFICERS

BENTON COUNTY MEDICAL SOCIETY
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Secretary-treasurer, V. L. Turley, Fowler

CASS COUNTY MEDICAL SOCIETY
President, D. E. Lybrook, Young America
Vice-president, C. Toney Dutchess, Galveston
Secretary-treasurer, H. M. Shultz, Logansport

CLAY COUNTY MEDICAL SOCIETY
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Vice-president, C. C. Sourwine, Brazil
Secretary-treasurer, Robert K. Webster, Brazil

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Secretary-treasurer, O. E. Wilson, Elkhart

FAYETTE-FRANKLIN COUNTY MEDICAL SOCIETY
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Vice-president, L. N. Ashworth, Connersville
Secretary-treasurer, R. H. Elliott, Connersville

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President, A. P. Hauss, New Albany
Vice-President, J. V. Pace, New Albany
Secretary-treasurer, Phillip Cohn, New Albany

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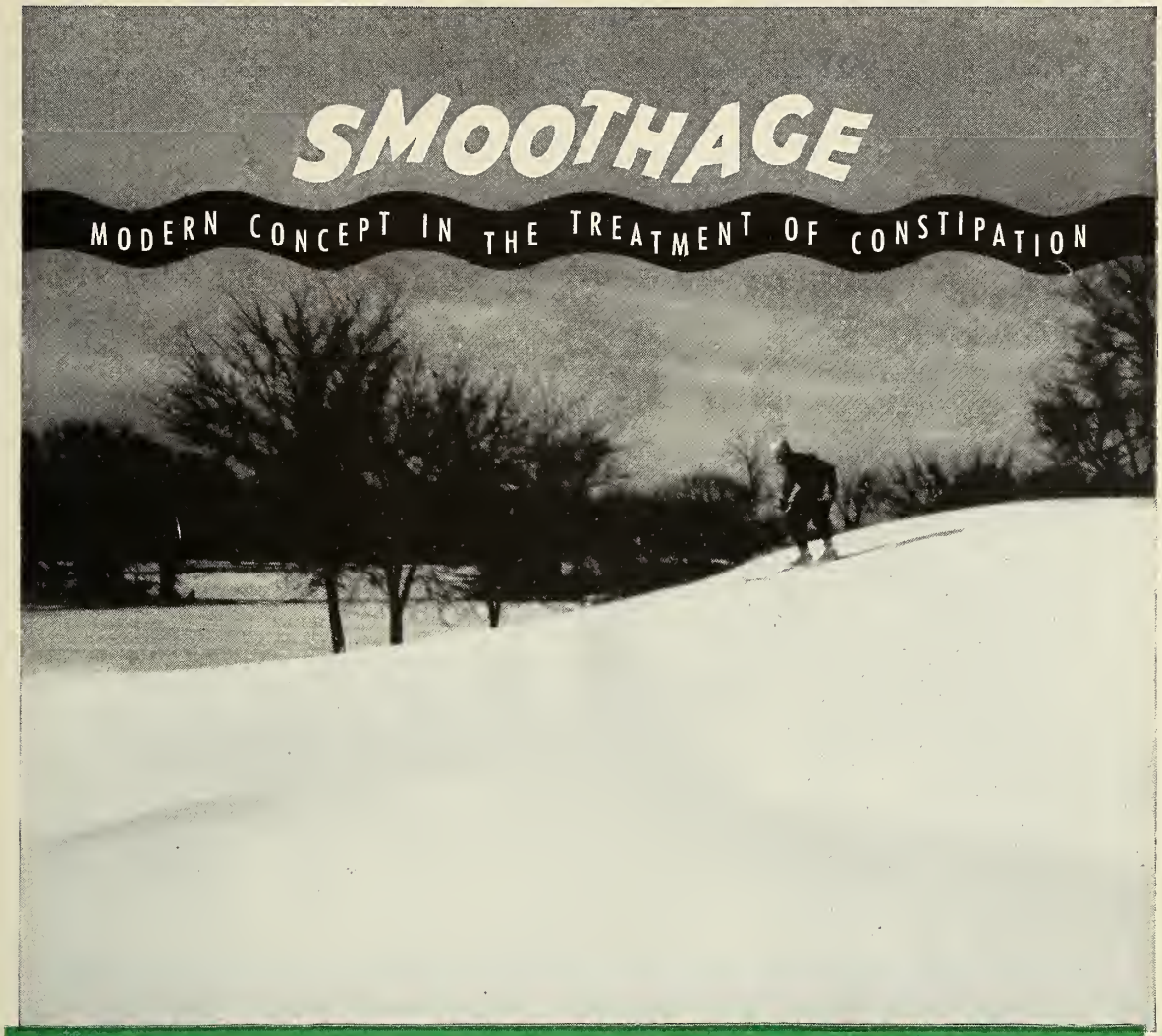
President, A. F. Connoy, Westfield
Vice-president, F. P. McDaniel, Atlanta
Secretary-treasurer, O. D. Havens, Cicero

JAY COUNTY MEDICAL SOCIETY
President, A. C. Badders, Portland
Vice-president, J. E. Nixon, Portland
Secretary-treasurer, Frederick Streib, Redkey

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Secretary-treasurer, Wemple Dodds, Crawfordsville

**MORGAN COUNTY MEDICAL SOCIETY**
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Secretary-treasurer, Henri LeClaire, Martinsville

**SCOTT COUNTY MEDICAL SOCIETY**
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President, Charles J. Hufnagel, Richmond
Vice-president, Marion Eugene Clark, Cambridge City
Secretary-treasurer, Harry Plummer Ross, Richmond

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**CASS COUNTY MEDICAL SOCIETY** members met at the Cass County Hospital, at Logansport, on January eighteenth. The speaker for this meeting was Dr. Thurman B. Rice, of Indianapolis, who spoke on "Postwar Planning." Twenty-two members and guests were present at this meeting, the doctors having invited the members of the Woman's Auxiliary.

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**CLAY COUNTY MEDICAL SOCIETY** members met on January twenty-fourth at the Aydelotte Restaurant, at Brazil. The meeting was held for the election of officers, and was attended by six members.

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**DEARBORN-OHIO COUNTY MEDICAL SOCIETY** members held a meeting at the Public Library Auditorium on January twenty-fifth. The six members present participated in a round-table discussion on legislative matters.

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**ELKHART COUNTY MEDICAL SOCIETY** members met on February first at the Hotel Elkhart, in Elkhart. The guest speaker at this meeting was Dr. W. D. Paul, assistant professor of Internal Medicine at the University of Iowa, who presented a paper on "Infectious Mononucleosis." Thirty-eight members attended the meeting.

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**FLOYD COUNTY MEDICAL SOCIETY** members met on January twelfth at New Albany, for the election of officers. Ten members were present.

At another meeting on February ninth, at the Frances Cafeteria, in New Albany, the eleven members present discussed current legislative measures.

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**FORT WAYNE COUNTY MEDICAL SOCIETY** members met on January sixteenth at the Chamber of Commerce for their monthly business meeting. Nineteen members attended the meeting.

At another meeting at the Methodist Hospital, in Fort Wayne, on February sixth, the legislative program was discussed. The twenty-five members in attendance heard Dr. Doster Buckner, who spoke on "Delirium Tremens"; Dr. M. B. Catlett, who presented "Toxic Thyroid with Operation"; Dr. A. C. Bartholomew, who talked on "Laryngeal Diphtheria with Tracheotomy"; and Dr. Mahlon Miller, who discussed "Transvere Presentation with Placenta Previa Delivered by Cesarean."

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**HOWARD COUNTY MEDICAL SOCIETY** members met at the St. Joseph Memorial Hospital, in Kokomo, on February second. Robert E. Jewett, M.D., of Indianapolis, spoke on "The EMIC Program." Sixteen members were present.

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**INDIANAPOLIS (MARION COUNTY) MEDICAL SOCIETY** members met on February sixth at the Indianapolis Athletic Club. Drs. Otto Bakemeier, Murray Hadley, Walter P. Morton, John Dalton, and John W. Hendricks presented case reports.

At a meeting held on February thirteenth the following Indianapolis physicians took part in the program: Dr. Henry S. Leonard read a paper on "Gall Bladder, Duct and Bloodvessel Anomalies," which was discussed by Dr. W. D. Little. Dr. Robert L. Glass presented "Spasmodic Facial Neuralgia," which was discussed by Dr. C. K. Hepburn.

On February twenty-first the members met at Camp Atterbury, Indiana. The program was presented by the staff of the Wakeman General Hospital.

The following papers were presented: "Reconstructive Surgery of the Central and Peripheral Nervous System," with presentation of cases by Major McCravey; "Repair of Defects in the Long Bones," with presentation of cases by Major Banks; "Secondary Repair of War Wounds of Bowel" with presentation of cases by Captain Abell; "Filariasis," by Captain Rainey; and "Results in Plastic Surgery," with presentation of cases by Major Blocker. Approximately ninety officers and guests were present for dinner at the Detachment Mess.

Another meeting held on February twenty-seventh was devoted to a symposium on "Recognition and Treatment of 'Trivial Injuries.'"

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**JAY COUNTY MEDICAL SOCIETY** members met at the Country Club, in Portland, on January twelfth. The guest speaker was Dr. A. J. Huerkamp, of Fort Recovery, Ohio, who spoke on "Septicemia." Following the paper, the eleven members present elected officers for the following year.

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**LA GRANGE COUNTY MEDICAL SOCIETY** members met on January fourth for their annual meeting, at the home of Dr. C. H. Schulz, of LaGrange. Problems of the current difficult period were discussed. Five members attended the meeting.

## WOMAN'S AUXILIARY

**We are very sorry, but because of the paper situation it was necessary to omit the Woman's Auxiliary news from this issue.**

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# THE JOURNAL
OF THE
# INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

*ISSUED MONTHLY under Direction of the Council*

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 38 APRIL, 1945 Number 4


## TREATMENT OF RHEUMATIC FEVER*


NEWELL C. GILBERT, M.D.

CHICAGO, ILLINOIS


I am sure that I do not need to warn you that I am not going to tell you how to cure rheumatic fever, or that I am not at all likely to tell you anything which you do not already know. I would remind you, however, how important rheumatic fever is as a public health problem. More children die of rheumatic fever between the ages of ten to fourteen than from any other one disease. About two out of every hundred school children have rheumatic fever. Rheumatic fever remains an important problem throughout life, as a cause of death from heart disease. In a disease productive of so much death or incapacity it is wise to look about us to see just where we stand—to catalogue what we know and what we do not know. Here we can do this only in part.

Our position in regard to the prevention of rheumatic fever would be very much better if we knew more as to what causes this disease. We know that it is closely related to the common cold. Coburn[1] has offered very good evidence that the hemolytic streptococcus is involved, as in the common cold, but the same organism may involve a whole family of children and only one may develop rheumatic fever. It would seem that its occurrence must be conditioned by some factor in the host, as well as by the invading organism. There is reason for supposing that rheumatic fever may be the result of hypersensitization, not to a specific organism but to some indifferent organism or some other agent. It is not necessarily the hemolytic streptococcus, but is usually so, because it is the most frequent invader of the upper respiratory tract. Rich[2] has been able to reproduce most of the anatomical lesions characteristic of rheumatic fever by hypersensitization in the experimental animal.

There are some parts of the country where rheumatic fever is less common than others, and climate probably plays some part. It is not as simple a problem as we used to think, and is not simply a matter of sunshine or dampness or altitude alone. One probable reason why it is so uncommon in the tropics and subtropics is because there is less crowding and less chance of spread by droplet infection. Crowded living quarters, crowded public conveyances, and crowded places of amusement are doubtless factors, because of the spread by droplet infection. Social conditions are probably not so important of themselves.

Tonsillectomy does not prevent either the occurrence or the recurrence of rheumatic fever. That does not mean that diseased tonsils should not be removed, but it does mean that they should not be removed just because they are tonsils, or large, or because the child has occasional attacks of tonsilitis. The tonsils are there as a part of a line of defense. Only when their usefulness is impaired by their being permanently infected should they be removed. Very frequently tonsillectomy is followed by a hypertrophy of the lymphadenoid tissue of the throat, and a granular pharyngitis results which is a constant source of infection very difficult to treat adequately. Granular pharyngitis does occur regardless of tonsillectomy, but is apparently more frequent after tonsillectomy.

There is one thing that does help, and that is summed up in a report of the British Medical Re-


* Presented before the Medical Section of the Indiana State Medical Association, at Indianapolis, October 4, 1944.


[1] Coburn, Alvin F.: *The Factor of Infection in the Rheumatic State,* Baltimore, Williams & Wilkins, 1931.

[2] Rich, A. R., and Gregory, J. E.: Experimental Evidence That Lesions with the Basic Characteristics of Rheumatic Carditis Can Result from Anaphylactic Hypersensitivity, *Bulletin Johns Hopkins Hospital,* **73**:239, 1943.

search Council as "Maternal Care."[3] Maternal care means an adequately planned diet, proper rest before and after meals, and adequate sleep. It means supervised activities and the avoidance of fatigue, for fatigue predisposes to infection. It means seeing that the child is properly clothed, and that he avoids exposure. It means care after exposure. It means avoiding contact with those who have upper respiratory infections. It means consulting the physician when the child is apparently well, but especially for what may seem to be only minor illnesses. It means a sufficient period of convalescence after minor illnesses. The parents must be taught to be on their guard for that subclinical condition which so often precedes rheumatic fever when the child is below the level of normal good health for his age, Vining.[3]

Various sulfonamides, and especially sulfanilamide, have been used in daily small doses over long periods of time as a prophylactic agent against upper respiratory infections and the resulting recurrence of rheumatic fever. That it is effective is evident from the reports of Coburn and Moore,[4] Dodge, Baldwin and Weber,[5] Hansen, Platou and Dwan and others.[6] Messelhoff and Robbins[7] did not confirm these results.

If such prophylactic treatment is used, the patient should be under constant observation. The sulfonamide levels in the blood must be watched, and blood, urine, and general conditions guarded closely. If it is used, other possible disadvantages must be kept in mind. We are not sure what tissue changes may result from the prolonged use of even non-toxic doses. We have good reason to think that a tolerance may be acquired which will render the drug useless in some serious emergency. We know that a serious hypersensitization may result from the use of small doses of the sulfonamides which will again prohibit their use when some later emergency may arise.

The most important demand in the treatment of rheumatic fever is its immediate recognition and immediate care and bed rest, even with the mildest symptoms. The bed rest must be absolute and continuous.

We do not know the specific etiology, and there is no specific treatment. Removal of so-called "focal infection" is useless. There should not be any uncared-for infection at any time. If such foci have evaded attention and care, their removal will not directly influence the course of the disease.

It is needless to go into a history of all the specific drugs, sera, and vaccines that have been used at one time or another. Penicillin and the sulfonamides do not help. The only drug that has stood the test of time is salicylic acid and the salicylates. They have been used continuously since salicylic acid was first recommended by Stricker, of Berlin, in 1876. Various doses, large and small, have been used. As Hartshorne said in editing *Reynold's System of Medicine*, in 1880, "No other treatment of acute rheumatism has as yet received so much testimony in its favor." The same can be said today, even if Lightwood did compare salicylate therapy to "a hose pipe that was not quite long enough to put out the conflagration." It probably has not been used in sufficient dosage. I was taught by my old chief, Dr. Robert Preble, to use up to 150 or 180 grains a day, or even more. I was discouraged by a few instances of gastrointestinal symptoms, headache, deafness, tinnitus, and urticaria. Coburn's results have made me take a backward look over the results in the wards of St. Luke's at that time, and to regret that I was so easily discouraged.

If the immediate attack could be treated in a way which would cut the attack short at the onset to prevent cardiac and other involvement, it would solve the most serious aspects of the problem. Coburn[8] showed that small doses of three to six grams daily relieved the pain but did not shorten the course. But when he used doses of 10 grams or more daily, by mouth or intravenously, in thirty-eight patients, none developed clinical signs of valvular heart disease and the course was shortened to as low as one month. A blood level of 350 to 400 gammas is necessary. At lower levels inflammatory changes continue. This blood level is reached more rapidly by intravenous administration, and may be maintained by oral administration.

Salicylate therapy should be controlled by blood level determination, and the sedimentation rate watched. It is too early yet to pass any final judgment upon its effectiveness or possible toxic effects. I would be willing to trade off some toxic effects, for they are never very serious, for a drug that would prevent cardiac manifestations. As Coburn himself states, it is not the final solution of the problem, but it is closer than anything yet proposed.

Meyer and Howard[9] have called attention to the danger of hemorrhage with large doses of salicylates. Clinically, the danger is probably not very great, and a decrease in coagulation time might possibly be an advantage. It can be prevented by vitamin K administered with the salicylates.

[3] Vining, C. Wilfred: The Pre-rheumatic Child, *Proceedings of a Conference on Rheumatic Diseases*, Bath City Council, Bath, 1928.

[4] Coburn, A. F., and Moore, L. V.: The Prophylactic Use of Sulphonamides in Streptococcus Respiratory Infections with Especial Reference to Rheumatic Fever, *J. Clin. Invest.*, **18**:149, 1939.

[5] Dodge, K. G.; Baldwin, J. S., and Weber, M. W.: The Prophylactic Use of Sulphonamides in Children with Rheumatic Fever, *J. Pediatrics*, **24**:483, 1944.

[6] Hansen, A. E.; Platou, R. V., and Dwan, P. F.: Prolonged Use of Sulfonamide Compounds in Prevention of Rheumatic Recrudescences in Children, *Am. J. Diseases of Children*, **64**:563, 1942.

[7] Messelhoff, C. R., and Robbins, M. H.: Prophylactic Use of Sulfonamides in Children with Rheumatic Fever, *J. Lab. and Clin. Med.*, **28**:13323, 1943.

[8] Coburn, Alvin F.: Salicylate Therapy in Rheumatic Fever, *Bulletin of the Johns Hopkins Hospital*, **73**:435, 1943.

[9] Meyer, Ovid O., and Howard, Beryl: Production of Hypoprothrombinemia and Hypocoagulability of Blood with Salicylates, *Proc. Soc. for Exp. Biology and Medicine*, **53**:234, 1943.

We still must fall back upon the two therapeutic agents which we know are of value—absolute rest, and time. And there must be a great deal of both. Rest and time must be observed until the temperature, pulse, respiration, and sedimentation rate are normal, and have remained normal for weeks, and, as Dr. McCullough advises, until the patient is gaining weight.

We know that there are frequently inflammatory changes involving the coronary arteries and decreasing their flow. We strongly suspect that some part, probably a large part of the muscular damage, is due to the decreased blood supply. We can not alter the anatomical changes, but we can use a coronary vasodilator drug. Dr. McCullough uses theobromine sodiosalicylate to increase the flow through the arteries. And when cardiac hypertrophy has resulted, and there are fewer vessels per unit of area to supply the hypertrophied muscle, such a drug is again of use. In this connection, it might be stated that sodium salicylate is a mild coronary vasodilator.

We should avoid meddlesome medicine. Digitalis has no place where the heart mechanism is normal or where there is no cardiac insufficiency; also, it is a good way to induce fibrillation. If a rapid fibrillation is already present or if there is cardiac insufficiency, that is a different thing.

When auricular fibrillation is once established, it is very improbable that the rhythm will ever return to normal. The patient should be taught in the convalescent home how to manage his own dose of digitalis. After the pulse rate which is the optimum for that individual has been established, it is not difficult to teach him how to maintain his pulse at that rate. This should always be individualized. The minute volume may be greater with a rapid pulse, or it may be greater with a slower pulse. There should never be any fixed rule as to pulse rate or pulse deficit. The only rule is the clinical result. The patient should be taught to vary the digitalis dosage so as to keep the pulse rate at that optimum level. He should never be sent home with a fixed dose of digitalis. A fixed dose will eventually prove to be either too much or too little.

When there is cardiac insufficiency with a normal mechanism it is much more difficult to handle. The dose is usually smaller and there are no criteria by which the patient can judge, except the amount of passive congestion and his general feeling of well-being. Such a patient should always keep in close contact with his physician.

And now I come to the part which I really wish to talk about:

I have spoken of rheumatic fever as a childhood disease, and so it is, in large part. But the initial infection or its recurrence may occur in any decade.

Whatever its background may be, it is an essentially chronic, long drawn-out disease, unless we really can cut short the intial attack before inflammatory changes occur. And that we do not yet know how to do. It may be arrested, but we can never be certain. We can never regard it as a closed incident. In addition, it is a generalized infection involving widespread tissue. Dr. Bruetsch, of Indianapolis, has shown histological changes in the central nervous system. A great many coronary occlusions give a history of rheumatic fever. We are not sure that it does not play a part in rheumatoid arthritis. It is responsible for death, for most of the cardiac diseases in early life, and for much of the cardiac disease in later life. It is a source of great economic loss. You have only to look about you in your own practice and in your own community to see its ravages. It is a major public health problem about which too little is being done. A great deal can be done and should be done by the doctors themselves, and not left to outside agencies.

It is obvious how little we as yet know. A great deal can be learned, not alone in the laboratory or clinic but by the general practitioner who sees his cases year after year, often through their lifetime. He knows their families and their environment. He does not get just a mere glimpse as they pass through the wards of the hospitals, but he lives with them, and he is able to see the whole picture in its perspective.

A great deal can be done and should be done to educate the people of each community in regard to rheumatic fever. Parents should be told of the importance of maternal care in the prevention of the disease. They should be taught the importance of early recognition, and the importance of the indefinite periods of ill health which often precede rheumatic fever. They should be taught the importance of keeping in close contact with the physician. A great deal can be done by the establishment of convalescent homes as city or as county projects.

Adequate and proper care of the more chronic phases, and especially of the cardiac involvement, may be possible in some patients' homes, but not in many. No matter how good the home and the home care, it will usually lack the advantage of close medical supervision and therapeutic aids, such as physiotherapy and occupational therapy. Most important of all, educational facilities are missed. It is a very hard thing for a child to lose one or two or three years of school and then have to go back into classes with a younger age group.

During the initial infection, or the early stages of recurrence, patients can be at home or in the hospital for study and intensive treatment. After the early stages they should be in a convalescent home, built and planned and operated for this purpose. The city hospital does not meet the requirements. We should avoid the hospital atmosphere, and we need the special facilities which the city hospital does not have. We wish to avoid the great expense of residence in a city hospital, which must carry a large overhead for operating rooms, laboratories, and other special facilities of which the convalescent patient is not in need. The cost per day in a convalescent home for rheumatic fever patients is less than half that of the city hospital. The cost per patient day of La Rabida in Chicago

is about $1.70, as against about three times that amount in the city hospital.

The convalescent home should be an integral part of the city hospital. It is very essential from the standpoint of efficient medical care that the same doctor who treats the cases in the hospital or the home should follow them through, and that the treatment should be constant, under one man, and part of a unified and continuous whole. The convalescent home should be open to all the physicians of the community. When the services of the parent hospital are necessary because of acute infection or surgical emergencies the patient can be at once returned to the parent hospital.

The convalescent home should be far enough out of the city to insure an abundance of sunshine from which the actinic rays have not been filtered out by city dust and smoke. It should be close enough to be of easy access to the attending physician, and to relatives, and to permit easy transfer back to the city in case of emergency. If there is a medical school in the city, the home should be available for teaching and for research. It should be situated in quiet, restful, open, and spacious surroundings of natural beauty. There should be facilities for out-of-door recreation when the condition of the patient permits. The city schools should provide facilities for the continuance of the regular educational program of the child, so that he will not have to return to take his place in school among younger classmates. There should be facilities for physiotherapy, for occupational therapy, and for entertainment. And I wish to emphasize especially that there should be facilities for rehabilitation and vocational training for those who will continue throughout life to be cardiac cripples. They must learn to do with their heads what they can not do with their arms and legs. They must be taught gainful occupations suitable to their physical condition, that they may be economically independent and not dependent upon the family or upon the state.

Patients should be kept in the convalescent center until they are entirely well and able to go back to school or to work, and to take their places in the community on their own feet.

The convalescent home offers the same advantages to other medical and surgical cases where the course is prolonged, and where the facilities of a city hospital are not necessary. This applies especially to orthopedic cases. They should not be asked to pay for residence in a city hospital when more adequate care can be given with pleasant, cheerful surroundings far from the hospital atmosphere, and at less than half the cost.

Such places should also be available as preventoriums. The rest and quiet and special facilities may serve to arrest many processes which would go on to levels which would be incapacitating without such facilities.

We in this country are very far behind what is being done in England, Russia, and elsewhere. The advantage in cost to the patient, and the advantage in securing proper care, is self-evident.

A good example of what can be done is afforded by Janesville, Wisconsin. There, Dr. Vincent Koch is talking before the businessmen's clubs, the parent-teacher associations, and other organizations, using slides of material furnished by the Metropolitan Life Foundation. Funds are being raised for a convalescent home.

Madison, Wisconsin, already has started a convalescent home, thanks to Dr. Kurtz. In Chicago we have La Rabida, where the patient can stay as long as is necessary, and several other institutions offering shorter periods of convalescence. There are similar institutions which we have not the time to enumerate. There are still not enough. In Chicago the school system has special schools for cardiac cripples. A bus picks them up and takes them home, and lunches are furnished by the schools. There are facilities for vocational education and training.

The need of such convalescent homes and of such public health measures as education of the public in regard to rheumatic fever is too obvious for further comment. It is work which should be done, and eventually will be done. I, for one, would prefer to see it done, not by social agencies or the state but by doctors themselves, and the direction and management should be kept in the hands of the doctors of the community.

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## ABSTRACTS

### PRIMARY CANCER OF THE LUNG

An otherwise fatal disease, primary cancer of the lung can be satisfactorily treated by surgical removal of the entire lung, William Francis Reinhoff, Jr., M.D., Baltimore, advises in *The Journal of the American Medical Association* for December 30. Surgical measures short of total removal of the lung are not efficacious, he says. Postoperative mortality and longevity are at least as good, if not better than those following the same treatment for cancer of other organs of the body.

### PENICILLIN FOR PERITONITIS

Investigations with animals indicate that penicillin should prove to be effective as an adjunct to surgery in the treatment of battle wounds of the abdomen and appendicitis and its complications, such as peritonitis, Lieutenant Commanders G. B. Fauley and T. L. Duggan, U.S.N.R.; Lieutenant (jg) R. T. Stormont, U.S.N.R., and Lieutenant C. C. Pfeiffer, U.S.N.R., reported in *The Journal of the American Medical Association* for December 30.

# SIGNIFICANCE OF OCULAR FUNDUS CHANGES IN HYPERTENSION

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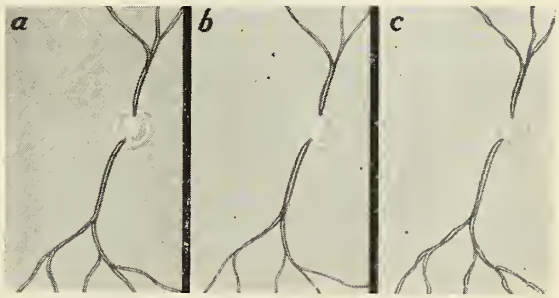
Bright (1936) was the first to point out that diseases of the kidney could produce visual symptoms. With the discovery of the ophthalmoscope, by Helmholtz (1851), a means was provided for observing the cause of these symptoms. In 1896 Riva-Rocci introduced the sphygmomanometer leading to the recognition of arterial hypertension as a disease. Shortly thereafter many investigators described the effects of elevated arterial blood pressure on the retina and its vessels. Little has been added to these original descriptions, but the clinical significance of fundus examinations has increased, with better understanding of hypertension. Experience has shown that ophthalmoscopic findings are essential for the diagnosis and management of this disease. However, the real value of this important study is not generally appreciated. For this reason the changes occurring in the ocular fundi of patients with arterial hypertension are here redescribed and classified.

Examination of the ocular fundus offers the only opportunity for direct observation of the arterioles and the effects of their disease on a highly-specialized structure, the retina. The retinal vessels are microscopic in size, but are easily seen with an ophthalmoscope because the media of the eye magnify the image about fifteen times. These vessels, beyond the primary branches, are classified as arterioles. They differ from arterioles in other parts of the body in that the thickness of the vessel wall is only one-tenth the diameter of the lumen. They receive additional support from the intraocular pressure. Changes in the retinal arterioles indicate a similar change in arterioles throughout the body although there may be a difference in degree. Duke-Elder,[1] referring to the retinal vessels, states that "in general the changes correspond with those found elsewhere in the body in similar circumstances." Castleman and Smithwick[2] observed a correlation between fundus findings and histopathologic alterations in the kidney, as studied from biopsy specimens of patients with high blood pressure. Before considering these changes it must be emphasized that they are independent of any process occurring in larger arteries, such as the aorta, coronary, or cerebral vessels. Sclerosis of these larger arteries does not develop as a result of hypertension, but occurs just as frequently in people with normal or low blood pressure, and may be absent in those with high blood pressure.[3] The principal changes in appearance of the retinal arterioles consist of constriction and sclerosis. Vasospasm occurs first, and if it persists sclerosis always follows.

### VASOSPASM

In early hypertension vasospasm is often difficult to visualize, and in the "neurogenic" stages may be absent for several years. However, in true progressive essential hypertension it eventually appears. The first manifestation is usually a change in the normal arteriovenous (A-V) ratio of 2:3. As a result of constriction the veins may appear two to three times the size of their accompanying arteries, and it is not possible to follow the arterioles to the periphery of the fundus (Fig. I-b). In other instances a segment of a vessel may appear spastic, so that the change in caliber of the narrowed portion can be easily observed (Fig. I-c). These abnormalities vary in degree from patient to patient, but whenever they are persistently present arteriolar sclerosis will appear.

FIGURE I




*Arteriolar spasm: a is normal; b is the generalized type in which the arterioles are uniformly narrowed; and c is the segmental type of spasm.*

### SCLEROSIS

While histopathologic studies of retinal arterioles are limited, it is well known that the earliest changes observed in the renal vessels of hypertensive patients consist of hyalinization of the intima, followed by hypertrophy and degeneration of the media. Proliferation of the intima with partial or complete obliteration of the vessel involved is probably a later stage of the same degenerative

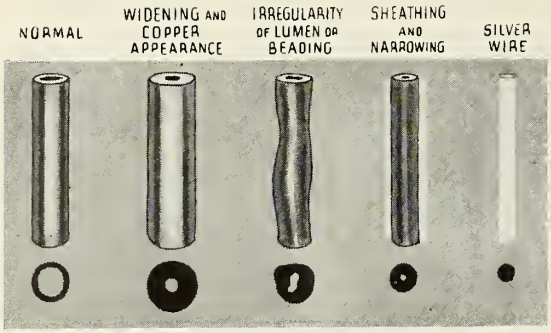
* From the Indianapolis City Hospital, Indianapolis, Indiana.

[1] Duke Elder, W. S.: *Text Book of Ophthalmology,* St. Louis, C. V. Mosby Co. 1941, Vol. **III**:2704-2720.

[2] Castleman, B., and Smithwick, R. H.: The Relation of Vascular Disease to the Hypertensive State, *J.A.M.A.,* **121**:1236-1261, (Apr.) 1943.

[3] Fishberg, Arthur M.: *Hypertension and Nephritis.* Third Ed. Lea & Febiger, Phila., 1935, p. 198.

FIGURE II




*Principal changes observed in retinal arterioles as a result of sclerosis, and effect on vessel wall and lumen.*

process.[4] Arteriolar sclerosis as observed in the retinal vessels could be due to a similar mechanism. Thus, the first ophthalmoscopic sign of sclerosis is a widening of the light reflex, which is probably due to an alteration in the transparency of the vessel wall as a result of intimal hyalinization and degeneration of the media. This early change may give the vessel a copper-wire appearance (Fig. II). As the degeneration progresses, proliferation occurs in the retina, making the lumen of the vessel appear irregular. This is often referred to as beading (Fig. II).

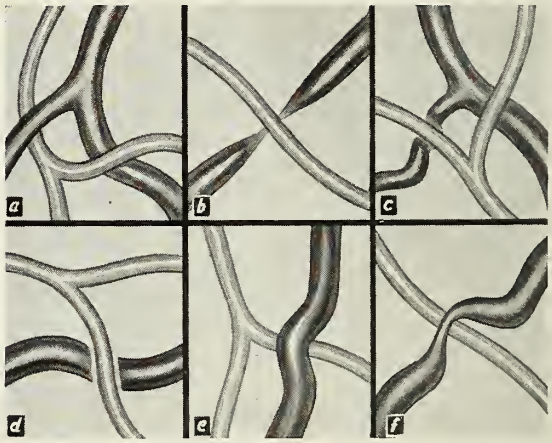
Another manifestation of sclerosis is sheathing, which is seen as a white line on either side of the vessel wall (Fig. II). Exactly what this represents is not known. It is believed by some to be a perivascular fibrosis. Friedenwald[5] believes it is due to atheromatous changes in the intima. If sclerosis continues the lumen becomes almost obliterated, so that the vessel wall will reflect light homogenously, giving the appearance of a white streak. There is no evidence of a blood column, and the arteriole resembles a silver wire (Fig. II).

Associated with thickening and sclerosis of arterioles is the appearance of crossing phenomena. Friedenwald[5] has shown histologically that the vein and artery are enclosed in a common adventitia at their intersection. He has also demonstrated that the intima of the vein is separated from the lumen of the artery only by the media of the artery. As a result of this intimate relationship sclerosis of the artery causes the soft vein to become displaced and compressed. This appears in the fundus as a tapering of the vein as it approaches the artery (Fig. III-b) or a complete disappearance of a segment of the vein (Fig. III-c & d). Where the vein crosses in front of the artery it is bent forward and appears to bridge the artery (Fig. III-e & f). When only minimal changes can be observed in the arterioles there may be no evidence of venous compression. In the presence of definite arteriolosclerosis some evidence of A-V compression is usually noted.

Sclerosis tends to cause a narrowing of the arterioles which alters the normal A-V ratio from 2:3 to 1:3, or more. Thus, it is very important to note the size relationship between artery and vein. In addition to the changes observed in the larger arterioles the macular twigs may have a corkscrew appearance. This may be difficult to evaluate. However, when present it is further evidence of hypertensive vascular disease.

In summary, early visible arteriolar changes are first evident in the light reflex which becomes widened and takes a metallic muster. Later the vessels become sheathed and may appear as silver wires. The veins become involved in the sclerosing process at their intersection with arteries. The arterioles may be more tortuous, particularly in the macular region, and the entire arterial tree may appear attenuated. As formerly stated, spasm usually precedes or accompanies these changes. Regardless of the etiology of hypertension, its effect on blood vessels is the same; and when changes can be observed with the ophthalmoscope similar lesions may be assumed to involve most other organs in some degree.

FIGURE III




*Effect of arteriolosclerosis at intersection of artery and vein —a is normal.*

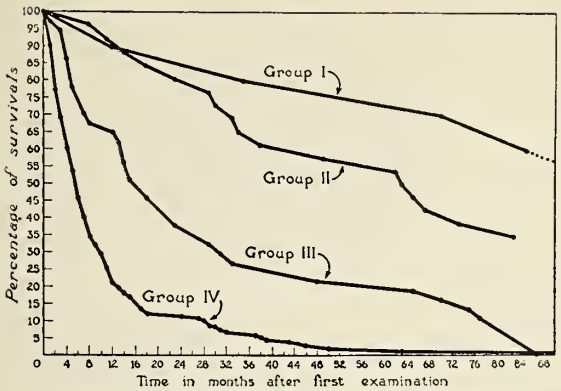
### HYPERTENSIVE RETINOPATHY

The appearance of retinal hemorrhages, exudates, and edema in the fundi of hypertensive patients has previously been referred to as albuminuric retinitis. However, since such lesions are not dependent upon albuminuria, and are not inflammatory, this is now considered a poor term and has been replaced by hypertensive retinopathy (Fishberg). Hemorrhages into the retina are usually flame-shaped because of their location in the nerve-fiber layer. They are frequently observed in close relationship to an arteriole. Less often round- or irregular-shaped hemorrhages may appear, and they are located in the deeper layers of the retina. Massive

[4] Moritz, Alan R., and Oldt, M. R.: Arteriolar Sclerosis in Hypertensive and Non-Hypertensive Individuals, *Am. J. Path.*, **12**:679-728, (Sept.) 1937.

[5] Cowdry, Edmund V.: *Arteriosclerosis*, Macmillan Co., New York City, 1933, Chap. 13.

FIGURE IV




SURVIVAL CURVES FOR THE FOUR GROUPS OF DIFFUSE ARTERIOLAR DISEASE WITH HYPERTENSION

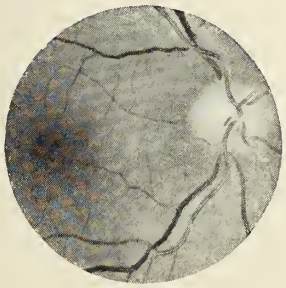
hemorrhages can occur. They are most often observed in the region of a vein, and indicate venous thrombosis. It seems probable that such a venous thrombus forms as a result of the irritative effect of a sclerosed arteriole where it crosses a vein.

The so-called "exudates of hypertensive retinopathy" appear as soft, fluffy, cotton-wool-like areas, or hard, shiny, sharply demarcated white lesions. The former may represent fibrinous exudates. Hyaline changes with deposition of lipoid and glial proliferation also appear as white patches. Absorbing hemorrhages and varicose dilatation of nerve fibers forming cystoid bodies can produce a similar picture. It is not always possible to determine the exact anatomic change from the ophthalmoscopic appearance, but the soft, white, fluffy areas are probably fresh lesions, while the others are older. Absorption of these exudates without permanent scar formation can occur.

The nerve fibers in the macular area are arranged in a radiating manner. If these fibers become separated by edema or occupied by many small, round degenerative lesions a star-like figure results. A macular star may be complete or incomplete.

*Papilloedema.* This sign is usually accompanied by marked vasospasm, varying degrees of arteriolar sclerosis, hemorrhages, and exudates. It is not easy to determine the presence of early papilloedema. The first sign is disappearance of the physiologic cup. However, the cup may not be completely obliterated, and a small slit remains. The next change is blurring of the disk margins. This is best noted at the upper, lower, and temporal borders, since the nasal margin is often blurred normally. As the process continues the disk will become elevated by a measurable amount. The edema usually extends to the surrounding retina, making it difficult at times to observe the arterioles. Filling of the perivascular lymph spaces accompanies these changes, and thus produces the ophthalmoscopic picture of white lines on either side of a vessel. As a result of the increased pressure in the optic nerve the veins become dilated and tortuous and appear darker than normal. The presence of papilloedema in a hypertensive individual almost always indicates malignant hypertension.

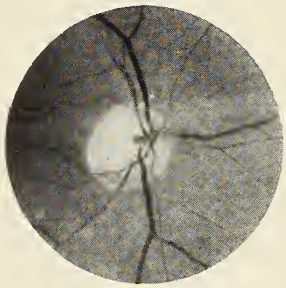
FIGURE V



*Forty-six-year-old female who had had hypertension for three years. Blood pressure averaged 178/110; specific gravity of urine 1.029.*

*Vessels show minimal changes consisting of a broadening of light reflex, and early A-V compression. A-V ratio is still normal.*

FIGURE VI



*Sixty-one-year-old male who had had hypertension for eleven years. Blood pressure 211/110. Urine specific gravity 1.016. Arterioles show beading and marked narrowing as a result of sclerosis and spasm. A-V ratio is 1:3.*

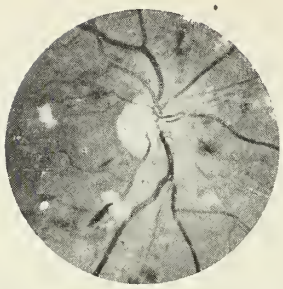
### INTERPRETATION OF FUNDUS FINDINGS

Hypertension is a disease which primarily effects arterioles. By examining the retinal vessels, an index of the amount of vascular change elsewhere in the body can be had. It is important to observe not only the presence of arteriolosclerosis, but also the degree. If retinopathy is not present, the prognosis for a patient with essential hypertension is usually good. However, when hemorrhages or exudates appear the prognosis immediately becomes poor. These lesions indicate extensive vascular damage even though it is not always apparent in the retinal vessels. The appearance of papilloedema is considered the gravest sign, since patients with this finding have malignant hypertension.

By classifying the ophthalmoscopic changes just described, Wagener and Keith[6] divided hypertensive

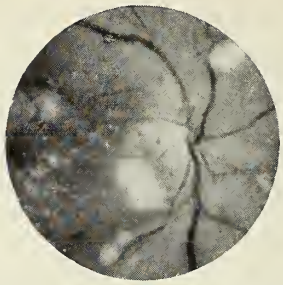
[6] Wagener, Henry P., and Keith, Norman H.: Hypertension and Associated Retinal Lesions, *Medicine*, **18**:317-430, (Sept.) 1939.

FIGURE VII



*Thirty-nine-year-old male who was told two years earlier that his blood pressure was elevated. Averaged 200/125. Urine specific gravity 1.016. Most significant findings are the numerous flame-shaped hemorrhages and fresh exudates. Vasospasm is also present.*

FIGURE VIII



*Fifty-six-year-old male who discovered he had hypertension several months before admission. Blood pressure averaged 223/142; specific gravity of urine was 1.015. Fundus shows all the typical findings of malignant hypertension—papilloedema, hemorrhages, and exadates. The vessels are markedly spastic.*

patients into four groups. Observation of two hundred hypertensives for five years or more showed a definite correlation between fundus findings and life expectancy (Fig. IV).

Group I included those patients who showed little or no vascular change (Fig. V).*

Group II was made up of those patients whose retinal vessels were definitely sclerotic and who usually show some degree of vasospasm. No retinopathy was present. Arteriovenous crossing phenomena were observed, and the A-V ratio is greater than 2:3 (Fig. VI).

Group III—These patients showed hemorrhages, exudates, or both, in addition to vasospasm and sclerosis (Fig. VII).

Group IV—Classification into this group depended upon the presence of papilloedema. The other vascular and retinal abnormalities were almost always present, but occasionally only papilloedema and vasospasm were seen (Fig. VIII).

* These are fundus photographs of patients examined at the Lilly Laboratory for Clinical Research, and were taken by the Illustration Department of the Indiana University Medical Center.

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# EMOTIONAL HYPERTENSION: A STUDY OF A GROUP OF HIGH SCHOOL BOYS

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There has been much recent interest in the subject of "Emotional Hypertension." It has been well known for many years that emotional stress would cause an increase in the systolic blood pressure. This has been repeatedly demonstrated, particularly in groups of soldiers.[1, 2] During the present war the Army has had to relax its regulations regarding pressure because of the large number of inductees presenting some elevation of pressure on first examination. The examiners have been able to prevent many rejections by having those men with an initially high pressure lie down for awhile, or even stay at the induction center overnight. In the early days of the war the physicians in practice saw men rejected for hypertension who had normal blood pressure at home, although this rarely happens now.

This same situation exists among applicants for work in the war plants. Almost all such plants now require blood pressure examinations. There, applicants are often examined while standing. As they are usually already in a state of mental agitation over their opportunity for a new job, the strain of a relatively unsympathetic, often hurried, examination does nothing to ease their mind. Therefore, it is not surprising that many of them are rejected for hypertension, or accepted with a warning that they should see their local physician, only to have the latter find their pressure quite normal a few hours later. Here

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[1] Alvarez, W. C.: Surprising Frequency of Hypertension in a Group of Young Drafted Men, *Cal. State J. Med.*, **17**:367 (Oct.) 1919.

[2] Cummings, R. S.: A Study of One Hundred Fifty Cases of Hypertension, *Cal. State J. Med.*, **17**:373 (Oct.) 1919.

again experience is proving a good teacher, and fewer rejections on a basis of hypertension are seen now. Many men are accepted with advice to see their local physician, or asked to see the plant medical staff at regular intervals for a few weeks so that the pressure may be checked.

Every doctor is aware of the fallibility of initial blood pressure readings. A large percentage of patients coming to a doctor for the first time will show some degree of hypertension, or an already present hypertension will be accentuated. In some patients this instability is so marked that it is almost impossible to get a normal pressure reading in the physician's office, or in his presence. Ayman and Goldshine[3, 4] conducted some interesting experiments on this subject. They had patients take their own pressures at home, or had some member of the family take it. These pressure readings were recorded frequently, and compared with readings made in the clinic on regular visits during the same period of time. They found lower pressures in a majority of the patients on home readings. One of their conclusions is quoted, ". . . the doctor is a form of standard pressor stimulus similar to breath-holding or cold." One may argue that with repeated visits to the doctor this stimulus would be less active, but they say, "It is our experience that a patient with essential hypertension can no more become non-reactive to the physician by repeated visits than he can become non-reactive to the pressor test of cold or breath-holding." One may not unreservedly agree with this conclusion, but they took the trouble to prove their point, while most of us have not done so. Personally, I can hardly feel that the pressor stimulus of the physician's presence is not partially mitigated by time and familiarity The current study presents some evidence for that belief, although it was done on normal individuals, and not on hypertensives.

Although this article is not concerned with the prolonged effects of emotional instability on the blood pressure, it must be pointed out that there is mounting evidence to show that early pressure instability is found in patients who later develop hypertension. Association of emotional disturbance with permanent hypertension remains without adequate proof, but no one can study the publications of the men who are working in this field without being impressed with the probabilities and potentialities in such work. Ayman,[5, 6] Ayman and Pratt,[7] Stieglitz,[8] Kylin[9] and Laufer[10] were considering this aspect of the disease ten to twenty years ago. More recently Weiss,[11, 12, 13, 14] Alexander,[15, 16] Morris,[17] Schwartz[18] and others have written on this phase of hypertension. Their work is most encouraging.

**TABLE I**

**BLOOD PRESSURE READINGS ON BOYS WHO WERE SEEN BOTH YEARS**

| *Patient* | *Blood Pressure 1941* | | *Blood Pressure 1942* | |
|---|---|---|---|---|
| | *Systolic* | *Diastolic* | *Systolic* | *Diastolic* |
| R. B. | 120 | 86 | 106 | 70 |
| R. C. | 136 | 80 | 126 | 86 |
| H. F. | 122 | 72 | 116 | 70 |
| D. F. | 128 | 74 | 126 | 76 |
| E. F. | 132 | 68 | 114 | 80 |
| W. H. | 126 | 72 | 116 | 70 |
| L. M. | 136 | 78 | 126 | 80 |
| S. M. | 126 | 70 | 116 | 68 |
| J. M. | 136 | 74 | 124 | 80 |
| R. S. | 120 | 60 | 108 | 70 |
| M. S. | 122 | 82 | 120 | 84 |
| A. S. | 126 | 54 | 120 | 76 |
| H. S. | 152 | 80 | 126 | 78 |
| R. T. | 122 | 80 | 116 | 76 |
| Averages | 128.8 | 73.6 | 118.6 | 76.0 |

This paper records some findings of interest in a group of teen-age youths. Because of a state law requiring examination of high school students before participation in athletics, I have examined many boys in the past few years. Three years ago the principal of a small neighboring high school asked me to come to the school and examine all the boys at one time, rather than having them come to the office. Twenty-two boys were seen at that time, and nineteen the following year. Fourteen of these were seen in both years.

[3] Ayman, D., and Goldshine, A.: Blood Pressure Determinations by Patients with Essential Hypertension, *Am. J. Med. Sci.*, **200**:465 (Oct.) 1940.

[4] Ayman, D., and Goldshine, A.: Blood Pressure Determinations by Patients with Essential Hypertension, *Am. J. Med. Sci.*, **201**:157 (Feb.) 1941.

[5] Ayman, D.: Normal Blood Pressure in Essential Hypertension, *J. A. M. A.*, **94**:1214 (April 19) 1930.

[6] Ayman, D.: An Evaluation of Therapeutic Results in Essential Hypertension, *J. A. M. A.*, **95**:246 (July 26) 1930.

[7] Ayman, D., and Pratt, J. E.: Nature of the Symptoms Associated with Essential Hypertension, *Arch. Int. Med.*, **47**:675 (May) 1931.

[8] Stieglitz, E. J.: Emotional Hypertension, *Am. J. Med. Sci.*, **179**:775 (June) 1930.

[9] Kylin, E.: *Die Hypertonie Krankheiten*, Berlin, 1926. P. 36.

[10] Laufer, O.: *Med. Klin.*, **23**:1150 (July 29) 1927.

[11] Weiss, E.: The Treatment of Illness of Emotional Origin by the Internist, *Ann. Int. Med.*, **14**:424 (Sept.) 1940.

[12] Weiss, E.: Psychosomatic Aspects of Hypertension, *J. A. M. A.*, **120**:108 (Dec. 5) 1942.

[13] Weiss, E.: Cardio-Vascular Lesions of Probable Psychosomatic Origin in Arterial Hypertension, *Psychosom. Med.*, **2**:249 (July) 1940.

[14] Weiss, E.: Recent Advances in Pathogenesis and Treatment of Hypertension, *Psychosom. Med.*, **1**:180 (Jan.) 1939.

[15] Alexander, Franz: Psychoanalytic Study of a Case of Essential Hypertension, *Psychosom. Med.*, **1**:139 (Jan.) 1939.

[16] Alexander, Franz: Emotional Factors in Essential Hypertension: Presentation of a Tentative Hypothesis, *Psychosom. Med.*, **1**:173 (Jan.) 1939.

[17] Morris, Don. P.: Blood Pressure and Pulse Changes in Normal Individuals Under Emotional Stress; Their Relationship to Emotional Instability. *Psychosom. Med.*, **3**:389 (Oct.) 1941.

[18] Schwartz, L. A.: An Analyzed Case of Hypertension, *Psychosom. Med.*, **2**:468 (Oct.) 1940.

TABLE II

BLOOD PRESSURE READINGS ON BOYS WHO WERE SEEN ONLY ONE TIME

| Patient | Blood Pressure 1941 Systolic | Blood Pressure 1941 Diastolic | Blood Pressure 1942 Systolic | Blood Pressure 1942 Diastolic |
|---|---|---|---|---|
| E. A. | 136 | 76 | ..... | ..... |
| J. C. | 132 | 80 | ..... | ..... |
| L. G. | 132 | 76 | ..... | ..... |
| C. G. | 128 | 82 | ..... | ..... |
| L. H. | 126 | 66 | ..... | ..... |
| W. H. | 144 | 90 | ..... | ..... |
| C. L. | 126 | 84 | ..... | ..... |
| A. N. | 120 | 70 | ..... | ..... |
| L. A. | ..... | ..... | 110 | 80 |
| B. B. | ..... | ..... | 110 | 70 |
| H. F. | ..... | ..... | 116 | 80 |
| S. H. | ..... | ..... | 134 | 86 |
| M. S. | ..... | ..... | 112 | 88 |
| Averages | 130.5 | 78.0 | 116.4 | 80.4 |

In 1941 the whole procedure was new to the boys, even though most of them knew me. They had never had a group examination at the school. In 1942 it was "old stuff," and they all knew what was coming. Each boy was examined while lying down, and the blood pressure taken on the right arm. Heart and lungs were checked during the examination. None of these boys had any organic heart disease or disease of the lungs.

The results are tabulated in the accompanying tables. Table I shows the findings in the group of boys who were examined both years. Table II includes those who were seen only in 1941 or 1942. Table III summarizes the results for all boys examined.

### COMMENT

Several points are of interest. Every boy who was examined both years showed a lower systolic pressure in 1942 than in 1941. This might be explained on an individual familiarity basis, but I do not think that it is the whole truth. When one considers the group in Table II, who were seen only once, there is a similar drop in the averages for 1942 as compared to 1941. In other words, the five boys being examined in 1942 for the first time showed none of the stress evident in all the group the previous year. The fourteen "veterans" from the preceding year apparently quieted the ones who were being examined for the first time.

A study of the individual systolic pressures reveals that in 1941 every boy had a pressure of 120 or more. Nine of the twenty-two were over 130, with one 144, and one 152. These boys ranged in age from thirteen to eighteen, with an average of sixteen, so that a mean systolic pressure of 129.4 represents a definite increase over the normal. In 1942 the average had fallen to 118. Ten of the nineteen then had pressures between 106 and 118, and only one was over 130.

TABLE III

SUMMARY OF THE AVERAGE BLOOD PRESSURE READINGS FOR THE ENTIRE GROUP EACH YEAR, AND FOR THE SEPARATE GROUPS OUTLINED IN TABLE I AND TABLE II

| | Blood Pressure 1941 Systolic | Blood Pressure 1941 Diastolic | Blood Pressure 1942 Systolic | Blood Pressure 1942 Diastolic |
|---|---|---|---|---|
| Entire Group | 129.4 | 75.2 | 118.0 | 77.1 |
| Boys seen both years (Table I) | 128.8 | 73.6 | 118.6 | 76.0 |
| Boys seen one Year (Table II) | 130.5 | 78.0 | 116.4 | 80.4 |

Considering only the fourteen boys who were seen in both years, the average systolic pressure was 128.8 in 1941, and 118.6 in 1942.

The boys seen only in 1941 had an average systolic pressure of 130.5, while those seen for the first time in 1942 averaged only 116.4.

As may be seen, the diastolic pressure showed no appreciable change, being within normal limits both years.

It would seem from this study that a type of group excitement was present in 1941, and a group nonchalance in 1942. This is to be considered as in addition to the normal personal excitement or nonchalance which might be operative.

### CONCLUSIONS

Blood pressure studies on a group of high school boys demonstrated the effect of excitement on the systolic blood pressure. These boys were examined in a group in 1941 and 1942. In the first year, when the procedure was new to them, average systolic pressures were high, while in 1942 they had fallen to normal. The new boys who were seen for the first time in 1942 showed no increase in systolic pressure, indicating that the nonchalance of the older members communicated itself to the newcomers.

Changes in diastolic pressures were not significant. This is in agreement with most published works on emotional hypertension. The systolic pressure is much more susceptible to environmental and emotional factors than is the diastolic.

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### "CANCER CONTROL"

Cancer still ranks second as the cause of death in Indiana and in the United States. One hundred sixty-five thousand death certificates annually give carcinoma as the cause of death. By an Act of Congress, and proclaimed by the President, April is designated as "Cancer Control Month." The attention of everyone is focused on the educational activities of the American Cancer Society, the Field Army, individual physicians, and the medical profession as a whole. For further details, read Dr. Don D. Bowers article on page 138.

*THE JOURNAL*
OF THE
INDIANA STATE MEDICAL ASSOCIATION
DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA
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APRIL, 1945

# Editorials

## MEETING WITH THE COUNCILS

Like most physicians, we long have heard about certain of the Councils of the American Medical Association, but first-hand acquaintance with these groups was not experienced until recently. On invitation the Advisory Committee to the Medical Cooperative Advertising Bureau met with three of these Councils on March ninth at the A.M.A. headquarters. Most of the day was spent as their guests. Certain matters of equal interest to both groups were discussed.

The Councils concerned in this meeting were The Council on Pharmacy and Chemistry, The Council on Physical Medicine, and The Council on Foods and Nutrition.

On entering the conference room we noted that the former group had under discussion a preparation that had been submitted by the manufacturers. A survey of this article was presented, accompanied by several pages of material submitted by the manufacturers. We were more than surprised to learn of the meticulous care in the discussion of the matter; we had no idea as to the scope of the investigation of material submitted to this Council, and came away from the meeting with a markedly-increased respect for that body.

Our particular concern, however, was a plea of our committee that state medical journal advertising was, in many instances, much reduced by the fact that it takes too long for the Council to act on a new product submitted by a manufacturer. The committee also felt that in certain instances Council rulings were such that much of our advertising was lost. It will be remembered that most state medical magazines do not carry advertisements of non-Council-accepted medical agents.

During the course of the discussion many interesting sidelights were developed. For example, one product, not passed on by the Council and introduced to the medical profession by the "sample by mail" route, and not acceptable in the advertising pages of the state medical journals, was found to be commonly used by many present at this meeting. One physician, recently a hospital patient, stated that his surgeon, a member of the faculty of one of our leading medical schools, had prescribed, not one but many, non-Council-accepted drugs for this physician-patient during his stay in the hospital. Another, a Council member, openly stated that he used and recommended a certain line of pharmaceuticals, none of which had the approval of the Council.

Much of the objection to many of the drugs and preparations submitted to the Council, it seems, is due to the name of the preparation. The Council had definite rules regarding this, and it seems that they are unable to condone any infringement of this rule.

Many other points concerning which the Cooperative Committee was quite in the dark, were discussed and at the conclusion of the meeting it was felt that at least the committee and the Council had a more definite understanding about many things. However, the committee came away from the meeting without much hope of an increase in advertising from the manufacturers of the disputed products.

There are some thirty-five state medical journals in the Cooperative Bureau, not all of which, however, are sticklers for the rules of the Council. Some of these magazines advertise perhaps not more than one or two such products, while a few go to greater lengths. It was explained that in one of these states the association had created a publication committee of five members who pass on all advertising, and that this committee made a thorough investigation of such products as had not yet been submitted to the Council. They consulted members from over the state, and in case a product was used chiefly by specialists in a certain field, eminent members of this specialty were consulted. If after such investigation it was found that the product was generally used, the advertising of the product was permitted in their state organ.

We still are of the opinion that the Council on Chemistry and Pharmacy has done, and is doing, a most valuable work; on the other hand, we are inclined to agree with many other state medical editors that a little "letting down of the bars" would hurt no one. Just now, of course, when ad-

vertisers in all fields are going the limit, and then some, in the matter of advertising appropriations, most state medical organs have little complaint about their advertising incomes. But, as Olin West well says, "this will not last forever; one of these days medical journals will be hard put to it to get advertising."

## POSTWAR PLANNING

Most organizations are at present engaged in postwar planning; this insofar as they are able to do so, due to the uncertainties as to when the war will end and what the economic state will be when that glad day arrives. However, it is of great importance that such planning be under consideration. Medical organizations, too, are thus engaged, but this article has to do with the plans tentatively being made by the Indiana Department of Conservation. They recently issued a brochure, setting out the things they have in mind during the next quarter of a century—events, which if carried out, will result in much good to coming Hoosier generations.

This organization has been operating for about twenty-five years, and in that time it has done a very good job of it. Today, Indiana is an outstanding state in the matter of conservation in general, and her state park system is a model, to the extent that each year we find delegations from other states coming here to see what has been done in Indiana.

This proposed program, which the Department terms a "Postwar and Long-Range Program," is a most comprehensive one. Not only does it cover the matter of additional parks and artificial lakes, an increase in the state nursery program, a marked step-up in the rearing of game fish for restocking our waters, as well as game for our fields and forests, but it also contemplates the restoration of our natural waters to their former unpolluted status. It plans for a much-needed increase in office space for the department, a permanent conservation exhibit in our state fair grounds, along with numerous other most necessary plans.

One phase of the problem is that of finances; heretofore, the greater part of the expense of the department was obtained through sale of hunting and fishing licenses, and the ten-cent admissions to our state parks. Much of the income from the first-mentioned source, the license department, will be cut off, due to the passage of a bill granting free licenses to all discharged veterans of our wars. We, of course, have no objection to such a procedure, but it is to be remembered that this "grant," on the surface, appears to be a gift from the state at large. This is not true; it is a grant, or gift, from the Department of Conservation. It amounts, or will amount when this war is over, to a very sizeable sum, something more than $250,000. This amount, in all fairness, should be made up to the department from the general fund of the state.

One phase of the new program appeals to us very strongly, that of planning to control artificial lakes. It is proposed that when a new lake is made the department be enabled to purchase the surrounding territory, thus effectually stopping the commercial exploitation of state-owned park land by "subdivision promoters." These new waters are the property of the state and are presumed to be used for the pleasure of our own folk, and those who choose to come in from adjoining states to see just what we are doing along these lines.

Also, we are much in accord with the program to further develop our nurseries—enlarge them, grow and sell more trees. These young trees should be used to fill up the vacant spots that at present are not of much value for farming purposes. Also, such trees should be planted in the strip-mine areas, most of which are now unsightly, nonproductive areas. Legislation is being enacted to compel strip-mine operators to replace the soil removed and to level it off. Thousands of valuable trees can be grown in these areas.

We are, of course, also interested in the anti-stream pollution program. There is no reason why the waters of Indiana should continually be polluted, to the extent that in many of them fish no longer can live. These waters are the property of the people of the state and should be restored to their natural state. Along this line, water conservation comes in for an intelligent discussion in these postwar plans. Folk living in central and southern Indiana do not need be told that our water levels are low—too low for solid comfort in some seasons of the year. Steps must be taken to correct this condition, for man cannot live and thrive without water. Forest protection is another matter that will have to be expanded. We are doing a pretty good job of this right now, but our annual forest-fire loss is much too high. There should be an increase in the number of state forests, and once these are established they should be well protected.

The above is but a sketchily-prepared comment of what our Department of Conservation has in mind for the future, but it will serve to show the enormity of the program and the dire necessity for carrying it out. As we have said, the greater part of this expense is borne by the park admission fees and the license fees. The state parks are self-supporting as it is, and the department asks no financial favor for its operation and maintenance.

Frankly, we believe we have one of the best Conservation Departments in existence; every member of the group is personally interested in seeing the plans carried out. It has been our pleasure to talk with several of these men, over the years, and without exception have they been enthusiastic about present and future plans for their department.

WAR BONDS—Buy them
and Hold them!

## ROLLEN W. WATERSON

Rollen W. Waterson, known to his intimates as "Henry," for many years executive of the Lake County Medical Society, has resigned that position to take a similar post with the Alameda County (California) Medical Association. Rollis Weesner, for some twenty years past connected with the Attendance Department of the Hammond City Schools, will succeed Mr. Waterson as the local executive secretary.

"Henry" came to this job without any previous experience with medical organizations, save for professional visits of physicians to his home; he says he knew nothing about doctors. Now, he declares, he could write a book!

He had been engaged in the "movie" business, as manager and even as theater organist; later he was associated with a local department store as public relations man. Then he took over the medical job.

He may be said to have been a pioneer in this job, in Indiana; it is certain that he was the first layman to take full charge of a county medical society in this state. Some idea as to the enormity of the program he introduced may be gained from the fact that he organized three medical business offices in Lake County—a central office only would not suffice because of the fact that the county has several large cities—four, in fact. He also organized four "branch" societies, this for the purpose of giving each section of the county proper recognition, and to enable each section to handle its own local problems.

The Council, composed of about a dozen members, had been a part of the organization for years, meeting when occasion required. Under the Waterson regime this body met each month, in breakfast session, the whole morning being given over to the business of the society.

Back in the old days we had a half dozen or so committees, some of which worked, but most of which did not. Under the czaristic program we have scores of committees, each of whom has a definite job, and does just that.

Realizing that most doctors are poor business men, Waterson installed a collection agency, and that surely did click. In one year that department collected more than $125,000 for Lake County doctors.

"Henry" is well known throughout medical Indiana, and in recent years has been invited to explain the Lake County setup in several parts of the country, both on the Atlantic and Pacific coast areas. Wherever he went he not only told what we were doing here in Indiana, but asked a lot of questions as to how things were being done in the sections he visited. That he could ask questions, we well know, for immediately after he had been installed in the new job the questions began coming in.

It just happened that we knew a bit about medical affairs in Lake County, as well as throughout Indiana, and Waterson took full advantage of that. Many problems arose, resulting in so many questions and requests for advice that we finally hit upon a system: When business matters necessitated it, we would get in the "official" Lake County Medical Society car and discuss matters en route to our destination. Going and coming, Waterson asked questions and expounded his theories, while we sat supinely by, managing to get in a few words, edgewise. First the instructor, and later the pupil, was our role over the past few years.

Waterson goes to his new job well equipped; frankly, we know of no other person who is so capable of taking over a big job such as the one to which he is going. The Alameda County Medical Society is one of the outstanding medical groups of the West. It never has had a lay secretary, and now wants one; it is getting the best one we know about.

"Henry" will be missed, not only in Lake County medical circles but throughout the state. He and his most estimable family—he has a brilliant wife and three gals, each of whom is entitled to the same adjective, "brilliant." We are certain that the entire medical population of Indiana wishes for the Watersons a continued success.

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## SPEAKING OF DOCTORS

The modern newspaper finds it highly necessary to have columnists, folk who adopt a head for their column, and from day to day write about this and that. Many such writers have a real following. *The Indianapolis Times* has several such writers, all of whose output is well worth the reading. Among them is John W. Hillman, who writes under the head, "Reflections."

Along in September, last year, we noted one of these articles which seemed unusually interesting. It promptly was earmarked for further consideration, and we just have gotten around to it.

He took occasion, as many other newspaper writers have done, to comment on Mrs. Eleanor Roosevelt's daily column, under the heading, "My Day." Hillman does not undertake to say whether he regards this output as having a high literary value; rather does he avoid that. He says, "sometimes she writes about human trivialities, but any smart newspaper editor will tell you that people are intensely interested in human trivialities"—and they are just that.

Again he says, "every now and then, too, Mrs. Roosevelt comes up with a piece that is good writing in any league. Such a piece was her column yesterday—September 11, 1944—on Dr. E. H. Bennett, the family physician of Lubec, Maine. In simple terms, and with real sincerity, she tells, in a few words, a great deal about one who, in her own words, was "a very great person." We quote:

"We get a picture of this country doctor, constantly on call in time of trouble, crossing the dangerous 'Narrows' in a rowboat in all kinds of weather because some-

one needed him and was depending on his skill and devotion.

" 'He knew the people who lived on the lonely island,' she says, 'on the poor farms, and in the little villages all around him, for he practiced medicine for sixty-six years.' Practiced medicine, we venture to say, with often little pay except the knowledge that he had done his duty and been true to his oath.

"He lived in an out-of-the-way place, but obviously he had the spirit of a great doctor. He was not content with what he knew, for 'many a time he went back to Johns Hopkins during the winter months.' And we suspect that it was not his technical skill, but his willingness to use it for whoever needed it—regardless of his personal comfort or whether his patient could pay in anything more than gratitude, and sometimes not even that—that won for him the 1937 award of the Maine Medical Society for 'outstanding service as a doctor.' "

We will let Hillman finish the tale. He does it so well and makes it clear that he is not for regimented medicine.

"We have known a great many doctors like Dr. Bennett, humble, yet great practitioners in Iowa, in Indiana, in Kansas, in Ohio, in Michigan and other states. They were able men, all, for theirs is an able profession. Yet they charged, not what their skill was worth, nor in proportion to the expense or inconveniences of their calling, but what they felt the patient could comfortably pay. And if that was nothing, that was all right—they were doctors, weren't they?

"They had the wisdom and understanding, too, of men who live for others, not themselves. So we can understand what Mrs. Roosevelt meant when she wrote: 'I looked upon him as a friend as well as a doctor, and I had the greatest admiration for him. He was calm and philosophical. He lived with people who did not make a fuss about little things. He had been in many a home where one did the best one could with what one had at hand, and he had little patience with anything that was not real, sincere, and courageous. His son is following in his footsteps.'

"As we read that, we wondered what Dr. Bennett thought about socialized medicine. As he looked back on his life of toil, self-denial and charity, we wonder what he thought of those who say that the doctors of America have not provided 'adequate medical care.'

"Had he been 'socialized' with patients assigned by a medical bureaucracy, we wonder if Dr. Bennett would have made those trips to Johns Hopkins in winter so he could serve his flock better. Would he have stood by so stanchly in the family crises, such as Mrs. Roosevelt described? Would he have been as ready to cross the 'Narrows' in the teeth of a storm? Would he? We wonder.

"Doctors like Dr. Bennett, and their name is legion, have always been socialized—not in the narrow technical meaning of the *Murray-Wagner-Dingell Bill,* but in the sense that they gave their lives in service to humanity; that they labored, not for pay but for the common good. To the poor and heavy laden they were and are, in both spirit and truth, the Good Samaritans. And much of their reward must be in heaven.

"Wouldn't it be a good idea to think a long time before we discard a system that produces such doctors?"

Have you paid your 1945 dues?

# Editorial Notes

Dr. Robert L. Swain, of New York City, has been elected as chairman of the United States Pharmacopeial Convention, following the death of former chairman, Dr. E. F. Kelly.

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It seems that pre-payment sickness insurance is a subject that just will not "down" in Indiana, although the matter has been under discussion for a long time—even special sessions of the House of Delegates and the Council having been held. Dr. W. U. Kennedy, of Newcastle, heads the new committee appointed by President Forster, and has announced that his group will get into action immediately.

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We wonder if the public realizes that although we have been through three years of World War, with thousands of our profession in the armed services, there has been no devastating epidemic, and that child mortality has not increased. Everyone grants that the physicians in the armed forces are doing a fine job in caring for war casualties, but it is also about time that the "home guard" men, who are working night and day to take care of the civilian population, be given full credit for their arduous labors.

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Our little comment on "corn silk" cigarettes seems to have attracted some attention from the lay press. The *Indianapolis News* had an editorial about the matter, and now we get a clipping from a Lansing, Michigan, paper, in which about the same comment was made as in the *News.* We had suggested that since scientific investigation has indicated that no harm could come from the smoking of this cigarette substitute that "Hoosier youth may continue this universal habit without untoward effect." Both papers conclude their comment with the statement, "Hoosier youth, indeed! What about adults, Hoosier, or no?"

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Again comes the month of April, known throughout the country as "Cancer Control Month." During the years that this activity has been carried on, the dissemination of knowledge concerning cancer has made the nation "cancer conscious." People want to know about cancer; they are concerned because they have learned that it continues to be one of the chief causes of death. They want to know the early signs and symptoms of cancer, and they want to know what to do about it. Every doctor has folk coming to him with the question, "Do you suppose that I am getting a cancer?" "Cancer Control Month" is a big event in this country, and medical men everywhere are urged to assist in the program.

Hamilton County wants a new hospital, and a fund-raising program has been in operation for some time. The local medical society has contributed one thousand dollars to the fund.

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There seems to be a current demand for more women physicians, several papers having recently carried editorials on the subject. Medical schools seem to have heard these demands and are making every effort to increase the enrollment of women. The Harvard Medical School finally has taken down the bars, and women students are now admitted thereto.

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We suggest that Hoosier folk not be too optimistic about an increase in gas allowance, even after the European war is ended. Officials have indicated that there might be some increase in the amount of gasoline allowed to folk in our section of the country, but that extra travel probably will be limited.

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The shortage of Army nurses continues, and although many plans have been suggested for the stimulation of enlistment of these valuable aids, the problem remains acute. We are, of course, all agreed that our civilian hospitals need our present nursing enrollment, and that certain home cases also need expert nursing care. But we must always remember that we are at war, and that our boys, too, are in need of the best nursing care available, which we like to think means *American nurses.*

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Well, the legislature "has been and gone," and the chiropractors still are without a special board. Their first attempt to obtain a special board was made so long ago that we have forgotten when, but they seem persistent and, no doubt, will be in evidence again, come 1947. If we had all the money this group has spent in trying to get special legislation we could buy enough cigarettes, at black market prices, to supply the Indiana medical profession for many years to come.

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One of the big jobs of a medical editor these days is to sift the great volume of matter that reaches his desk every day—not letters from our members or doctors in other parts of the country, but printed matter from the ever-increasing list of organizations, some of which have a right to existence, but some of which should not exist. The letter or brochure starts out interestingly, so we put it aside for future reading, thinking that we might perhaps pick up some new information. However, when we get around to reading these affairs we find that a lot of them are not so informative, after all, but are "boosters" for this or that product or device. And yet, we see by the papers that there still is a paper shortage, and that we must conserve in the matter of paper.

Vacation-time is just around the corner, but what to do about it, and where to go remains the sixty-four-dollar question, with no answer in sight. We had anticipated attending the Annual Sportsmen's show, recently held in Chicago, thinking we might find among the exhibitions a new fishing camp not too far away, and one that could be reached by train. However, due to an ODT order, issued just before the show opened, none but Illinois camps were permitted to exhibit, so there we are—still undecided.

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The *Indianapolis Star* editorially opines that the public would do well to let the doctors inaugurate a system of prepaid medical care, being of the belief that physicians know more about such matters than laymen. The writer concludes, "Members of the state organization should realize that prestige of the profession will be enhanced by evolving a workable insurance plan. Needless delay may result in having a less desirable plan imposed upon them."

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A meeting recently was held at S.E.C. headquarters, in Philadelphia, by a group of interested agencies, looking to some plan of enabling holders of War Bonds to avoid the chiseling groups that infest the entire nation, and whose activities are stepped up in postwar times. Immediately after World War I these shysters appeared all over the country, and in no time thousands of Liberty Bond holders found that they had been gypped, losing all of their investment. Just what form the present program will take is not known, but with the cooperation of many groups, particularly the Better Business Bureau, it seems that we are in a fair way to forestall the activities of these leeches.

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Like all other publications, THE JOURNAL has its problems, chief of which is in connection with our printing. Now let's get this straight, we have one of the best printing jobs in the country—many other medical journal editors are envious of us. Only the other day an editor from one of the southern states wrote us, asking how we managed to get such good color jobs, especially our front-page color work. So, we have no quarrel with the printer himself. Our biggest problem, however, is in trying to hold down on the number of pages published each month; in fact, we have been told that we have exceeded our quota, and that we must cut down. Hence, you will note that for the next few months we will have fewer pages, but we are having some of our material set in smaller type so as to conserve space and yet not lose much of its content value. Another matter that seems to concern other editors of state magazines is our paper; many of them want to know how we manage to get the high quality of paper we have been using. That, of course, was taken care of long ago by our printer, who laid in a sufficient stock to meet our needs for some time.

The Indiana press was very friendly to our profession throughout the recent session of the Legislature, in that their editorial comments regarding the major bills in which we were interested were very much to the point, and explained to the reader just why such legislation was needed. And, too, our newly-elected governor, Ralph Gates, showed a marked interest in such matters; wanted to know just what the situation was, and on getting the information did his bit in having the new laws passed.

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In looking over the 1920 volume of THE JOURNAL, we noted several references to compulsory health insurance, and are using a little note from one of these articles in our "Twenty-five Years Ago" column. THE JOURNAL came out strongly against the idea, as did many other state medical magazines. In another article it was stated that the American Medical Association had gone on record as being opposed to any such plan. (Note that this was twenty-five years ago.) It is our firm belief that had the A.M.A. at once gotten busy on a substitute plan, one that could have been operated and controlled by the physicians of the country, the thing would have gone over in a big way, and much of the present unrest about medical care would have been averted. We recall that a doctor from Michigan, whose name we do not now remember, said in a meeting of the Secretaries-Editors, *November, 1932*, when some such subject was under discussion: "Gentlemen, this is an important matter, but it is my opinion that we are about ten years late in getting interested in it."

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Don't count too strongly on attending medical conventions this year, for it is very probable that the stringent rules recently laid down by official Washington will not be relaxed to any great extent. Transportation problems, instead of being solved, are becoming more complex each day, and the railroads, et cetera, are being put to it to handle even necessary travel. Recently Olin West, secretary and general manager of the American Medical Association, told us that the applications for permits for several medical meetings had been turned down by O.D.T. authorities, but that he was going to see what might be done in regard to this year's regular meeting of the A.M.A. House of Delegates. Even with the ending of the European phase of the war apparently in sight, travel conditions will not be much improved. Thousands, yes, millions, of our boys will be coming this way, some to remain in this country, others to keep on going until they reach the Pacific area. It would be well for our Association officials to, first, make application for a meeting of our House of Delegates; failing in that, we would suggest that each of the thirteen districts appoint a delegate, or delegates, to an abridged meeting of our House. With "crack downs" becoming an almost daily occurrence, it would be well to do a bit of planning, just in case.

Some of the so-called "nursing homes" throughout the state will feel the "weight of the law" in the near future. Legislative action has been taken in the matter, and many of the abuses that formerly were found in some of these places will be abolished. Also, hospital control seems to be in the near offing, a matter that has needed drastic attention for some time. There are several such institutions not worthy of the name of "hospital" that have gotten by with numerous shady practices. Further, some of these places were more than insanitary—they were just plain dirty.

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The old-timers whose hair is beginning to turn a bit gray had hopes for the future in the advertisements stating that certain vitamins would restore the natural color of their hair. Vain hope! Now comes the announcement that federal agencies have cracked down on the promoters of this idea, having found that there is no basis for such claims. So the old-fashioned hair dyes will continue to serve those who dread the oncoming of a hoary-headed appearance.

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The Hoosier medical profession fared very well at the hands of the 1945 session of the Indiana General Assembly, as will be noted in a special article in this issue of THE JOURNAL. Outstanding among the new bits of legislation enacted, and signed by Governor Gates, are the bills reorganizing both the Indiana State Board of Health and the Indiana State Board of Medical Registration and Examination. Both of these boards sorely needed rejuvenation, if we may call it that. In the case of the Medical Board, which had operated under the basic law of 1897, conditions were such that it would soon have been absolutely impossible to appoint new members to that board, in strict conformity with the law. The Board of Health, while functioning far better than at any time in its history, had met many impasses and needed the setup that will exist under the new law. We are very glad to see the board enlarged, and to have members thereof other than physicians. For an analysis of the most important of these bills, we refer you to the article (on page 142) on "Indiana Health Legislation," by Dr. Thurman B. Rice, the Acting State Health Commissioner. Another bit of legislation that pleases us very much is the creation of a health school at the Indiana University Medical Center. For some time we have urged that this be done, feeling that the Indiana University Medical Center is fully equipped to do this thing as it should be done. The editor spent quite some time in conference with Dr. Thurman B. Rice in discussing this matter, as well as the reorganization of the Board of Health, and also talked with many others who were in a position to know the need thereof. Indiana is geographically located right in the middle of things, as we have said. We have the equipment and we have the manpower necessary to carry on, so let's get going.

# President's Page

## REGIMENT THE POLITICIAN

In this war, which is being waged to preserve the concept of free and democratic principles, it seems paradoxical that we should be seeking to follow economic measures of absolutism when we know that such a system has brought civil, personal, economic, and political disaster to our enemies, and was, in fact, the prime factor in causing the war. One cannot doubt that the majority of the American people believe completely in the system of free enterprise and competition, feeling that it has been responsible for this country's rise to prosperity, being confident of its basis to produce prosperity in the future. And yet we see a growing disposition on the part of the people to subscribe to the theory that a government of politicians possess a greater ability to plan a prosperous future than those actually engaged in the business, industrial, professional, and financial enterprises of the nation.

War-time confusion, emergency directives, usurpation of authority, link by link the chain is forged to bind the people to the will of professional planners who think in terms of vast and permanent power, while they assume their superiority in such terms as "planned economy" for the future. On the basis of such planning, Germany and Italy have sacrificed their freedom. On the establishment of such a precept in this country, we will sacrific ours. The complexity of industry; the geographical expansion of America; the development of intricate foreign relations; the problems of war; the replacement of political problems by economic problems, arising daily before officials elected not for economic knowledge but for political skill; the consequent diversion of power from elected incompetents to appointed experts, bureaus and boards—all these factors have conspired to make democracy unreal, a pretty window dressing for machines adept in herding votes, distributing favors, and barring the road to office for all but the subservient.

We cannot be satisfied with this kind of democracy any longer. An attempt should be made to rescue democracy from those who lend themselves so easily to its frustation. A way must be found of stealing the theoretical virtue of aristocracy—the restriction of office to individuals fitted for it by lifelong specific preparation—and inserting it into the principle of democracy, that every man and woman should have an equal chance to rise to the very top. Democracy must be re-defined, not as an equal right of all to hold office, but as the equal right of all to make themselves fit to hold office.

Beginning in the school, opportunity should be provided by scholarships to advance to higher training those who demonstrate ability and leadership. Universities should provide schools of administration as rigorous, exacting, and practical as our finest schools of medicine, engineering, and law. Educational requirements should be added to the present prerequisites for office, and entrance to training provided to all who can pass the tests. None but the graduates of such schools should be eligible to public office. Promotion would come as, step by step, experience was added to training, and as ability was demonstrated in accomplishment. Thus, would a pyramid of democracy be built upon the stones of equality of opportunity. Thus, would the officeholder perform his true function—an able servant of the people. Thus, would we overcome the dread and uncertainty that encompass the business, industrial, and professional world today.

"Your old men shall dream dreams, your young men shall see visions."

—*Joel 11, 28, c.—350 B.C.*

N. K. Forster

# THE PHYSICIAN AND CANCER CONTROL

DON D. BOWERS, M.D.

INDIANAPOLIS

Determined, aggressive attempts to control cancer ranks second only to the control of aggression of nations and the establishment of permanent, peaceful international relations in the list of human needs. The interest of physicians as individuals and the cooperation of the profession as a whole in our nation are essential to the accomplishment of both of these desires.

The cancer problem is openly recognized as such today, and the public generally is demanding more information about cancer, its prevention, and its treatment. It seems a deplorable fact that many in our profession, although having received a large measure of light themselves, have a desipient and often stubborn reluctance to affirmative efforts to transfer to the public the needed light in place of existing darkness.

It may not be untimely to suggest that many of the current hazards which beset our profession in its pathway may have resulted from such indifference and aloofness. A potent antidote is needed to counteract absurd edicts, and legislative measures which threaten to destroy initiative, freedom of enterprise, and individuality in the practice of medicine. Positive, vigorous, affirmative, and intelligent medical leadership, and support of and active cooperation with programs of enlightenment of an unenlightened public would go far in supplying such an antidote. *No more timely opportunity exists for the medical profession than that presented by cancer control.*

The public should look to the individual physician for leadership in cancer education, as well as for the detection, diagnosis, and treatment of the disease. Widespread educational programs have already been instituted. The American Cancer Society, through its Field Army, composed of lay groups throughout the country, is engaged in the most commendable projects in this sphere. This organization invites, and by right expects, the active cooperation of physicians in its efforts. Under medical supervision it is spreading knowledge of cancer to millions of people annually. Many of these individuals, urged to consult their physicians because of their having received this enlightenment, may prolong their lives.

The educational activities of the American Cancer Society will be more intense in the future under the program of reorganization recently announced by Dr. Frank E. Adair, of Memorial Hospital, New York City, the society's president. Evidence of the interests and cooperative desires of outstanding executives and professional men is apparent in the roster of the newly-elected Executive Council, of which Eric A. Johnston, president of the United States Chamber of Commerce, is chairman. Such an organization has the right to expect the outspoken approval and active cooperation of every physician in its sincere and unselfish efforts to carry out its educational objectives.

Competent medical authorities believe that the death rate from cancer can be lowered materially through widespread education. It is therefore an incumbency of every physician to cooperate in such efforts. Conceding that, as a profession, we have much to offer society in partial solution of the cancer problems of its individuals, although we are able, ready, and willing to help them, we cannot do so unless they have the knowledge of such ability, are willing to be helped, and will cooperate.

The argument that cancerophobia results from publicity about the disease is of minor significance. Balanced fear of pathological processes is a normal characteristic of educated people, and an exaggerated indulgence in such fear is present in those inherently inclined to cultivate psychoses in general. Also "it is better to be frightened than dead."

That most of the individuals who have had the good fortune to be impressed by educational efforts already instituted will more promptly and willingly consult their physicians has been demonstrated beyond doubt. This fact makes it increasingly obligatory that the physician train himself to think in relation to cancer detection and diagnosis. He must demand satisfactory explanation of all symptoms which might possibly indicate the presence of a potentially malignant or early-malignant lesion.

Dr. C. C. Little, formerly president of the University of Michigan, now managing director of the American Cancer Society and a recognized authority in the field of cancer research, has spent many years in the study and estimation of the possibilities in early discovery of cancer cases. He recently estimated that seventeen million persons now living will die of cancer, and added that five and one-half million could be saved from this group if their cases were discovered early enough. The responsibility of such early discovery will bear with increasing weight upon individual physicians.

Various types of cancer are known to be preceded by local deviations from normal tissue physiology. The view that cancer arises, not in normal tissues but in tissues which have been for a long time exposed to one or another of the agents or influences which are grouped under the term "chronic irritation," is of widespread acceptance. It is probable that many of the commoner forms of cancer come within this category. Although in many instances the exact transition into cancer has not been proved, the importance of the processes known as "exciting factors" is dictated by clinical experience. The change from a benign tumor to a

malignant one is not infrequently observed. Many known carcinogenic agents—chemical, physical, or biological—produce primary inflammatory changes, then benign tumors, and finally cancer. These facts make possible the prevention of cancer by the recognition and treatment of "precancerous" biological states and diseases, and benign tumors, while they are not yet cancer—only potentially so.

The potential value of the detection and correction of such conditions, and the accuracy and success with which treatment may be accomplished, has been recently demonstrated by Drs. Catherine Macfarlane, of Philadelphia; Elise L'Esperance and her associates, in New York; Augusta Webster, of Chicago; Harold Harvey, of the Presbyterian Hospital in New York, and others.

The physician will indeed be neglecting one of his chief responsibilities (another of those which he "gets for being a doctor") and opportunities for services if he is either unable or unwilling to recognize and advise appropriate treatment for "precancerous" lesions and tumors. Efforts are being made to develop in the mind of the American public the habit of reporting for periodic physical examinations even in the complete absence of any symptoms that would indicate the need of medical attention. Such "detection examinations" often called "check-ups" by the layman, will surely bear no fruit unless the individual physician schools himself in the consciousness of potentially hazardous, although often subjectively symptomless, conditions and habits of living.

The apparently obvious bearing of this policy, and the possibilities in relation to the whole future of preventive medicine, on the development of programs of health education, and on the correction of many conditions (not only cancer, but a large number of other diseases) before hospitalization is necessary and the economic complications and loss of manpower result, makes this work of vital importance to the American public.

Dr. Thurman B. Rice, public health authority, in his recent recommendations regarding the future health program of the Indiana State Board of Health, indicated the urgent need for, and social importance of, thorough investigation of the possibilities in cancer control in our own state.

"Happy the day" when the supreme business of the medical profession may be to keep humankind well instead of endeavoring to aid in their repair after they have become ill. The triumphs of preventive medicine already glow with radiance as the greatest achievements of our profession. Glorious, indeed, will be the dawn of that tomorrow whose rising sun looks upon a profession whose greatest concern and highest ideal shall be to maintain, foster, and preserve the continued well-being, the normal vigor of health, undimmed and unsullied by the many ills to which mankind is now required to bow because we have not yet reached that wonderful day. By conscientious and continued efforts of all individual physicians their profession may accomplish achievements tomorrow which are today but the vision of their fondest dreams.

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## WELL-ROUNDED HEALTH PROGRAM ENACTED BY STATE LEGISLATURE

During its ninety-six years of long and honorable service in the interest of the public welfare of the citizens of Indiana, the Indiana State Medical Association has never sponsored such a far-reaching and important legislative program as that which was enacted into law by the eighty-fourth session of the General Assembly which adjourned March fifth. It was, indeed, a program which would have brought great satisfaction to such medical legislative leaders of the past as Dr. John N. Hurty, Dr. William N. Wishard, and Dr. Frank Cregor. In scope and vision it is greater perhaps than anything ever proposed in the past, from the public health standpoint, and successfully enacted into law during any single legislative session. Many of the principles so ardently proclaimed for years by Doctor Hurty are interwoven in the public health program recently enacted. Principal points of the Indiana program are the creation of a public health school, the establishment of a psychiatric clearing hospital, broadening of the organization of the State Board of Health, strengthening of the powers of local public health departments, and the creation of a public health advisory council, which will be composed of representatives from many agencies and groups in Indiana who are interested in public health.

Although at its inception its importance perhaps was not recognized, among the most important measures of the entire program is the one providing that a survey shall be made by the State Board of Health as a basis upon which Federal grants will be accepted for hospitals and health facilities in this state. This is a most valuable and foresighted bit of legislation, for it anticipates the passage of the Hill-Burton Bill that is now being considered by the United States Senate, whereby $105,000,000 will be available for hospital construction. The Hill-Burton Bill is sponsored by the American Hospital Association, and has been approved in principle by the American Medical Association. It provides that the survey shall be made and the funds granted upon the basis of local needs, and that the control shall come from the local unit rather than from the Federal Government insofar as possible.

Before making its detailed report upon the enactment of legislation, your committee takes this op-

portunity to express its deep gratitude and appreciation to Governor Gates for his splendid cooperation and help. Throughout the years the profession and the public have been unusually fortunate in the fact that almost without fail Indiana governors have been vitally interested in the health of the citizens and well founded in the knowledge of the problems and the viewpoint of the medical profession. At the present time, while governors in other states have lent a hand or have listened to the seductive appeals of socialized medicine, and in some states have even proposed and are promoting compulsory health insurance bills of their own, Governor Gates, realizing the importance of maintaining high standards of medical care for all, has continually been in touch with the members of the medical profession, and has consulted with its leaders in formulating the health program which was enacted by the General Assembly.

The public health program of Indiana is covered in a special article in this issue, prepared by Dr. Thurman B. Rice, acting state health commissioner.

### STATE ASSOCIATION BILLS

The Indiana State Medical Association sponsored two bills, the most important of which was the bill to modernize the Indiana State Board of Medical Registration and Examination, which passed with only a few dissenting votes and was signed by the governor.

The second bill, which would have allowed physicians to serve on hospital boards, was not pressed by the profession after its introduction, due to the fact that it was thought best to attempt a solution of this problem through the courts rather than through legislation.

### CULT LEGISLATION

The usual number of cult bills was introduced. A bill which would have allowed the creation of a separate board of chiropractors was introduced in the Senate and defeated on third reading by a vote of 6 to 24. Another chiropractic bill, which would have allowed all chiropractors serving in the armed forces to be licensed in Indiana without taking an examination, was introduced in the House of Representatives and was defeated by a vote of 25 to 59. A naturopathic bill was introduced in the Senate but did not get out of committee.

### OSTEOPATHIC BILL

Perhaps the bill which has caused the most discussion by the members of the profession is the bill which was passed giving the osteopaths the right to practice medicine, in addition to surgery and obstetrics (which right they have had for a number of years), upon taking the same examination in medicine as is required of medical students. At the time of the presentation of this bill the Council of the Indiana State Medical Association went on record as neither favoring nor opposing this bill. The bill passed the House 69 to 10, and after it reached second reading in the Senate a special legislative meeting of the Council and Legislative and Executive Committees was called, at which it was voted to oppose this bill. Although the Legislative Committee sent forth numerous bulletins and kept the members of the profession constantly in touch with the progress of this bill, only a few county societies made any protest to their senators against this bill. Hence, the bill passed the Senate with only one dissenting vote, and was subsequently signed by the governor. A statement by the attorney of the Indiana State Medical Association in regard to the meaning of this bill follows:

"This bill changes the 1923 Act, under which certificates to practice osteopathy, surgery, and obstetrics were issued on the same terms and conditions as certificates to practice medicine, except that the applicant therefor was not required to pass an examination in materia medica. He was required to show that he graduated from a college which conformed in all branches of instruction, except in materia medica, to the standards fixed by the Medical Board. *The Medical Board itself continues to determine whether a school conforms to the standards fixed by the Board.*

"Under *House Bill 176*, a certificate for a license would be issued to a graduate from a school of osteopathy to practice *osteopathy, medicine, surgery, and obstetrics* on the same terms and conditions as certificates to practice *medicine, surgery, and obstetrics.*

"The terms and conditions on which certificates to practice *medicine, surgery, and obstetrics* are granted are:

> First, that the applicant be a graduate from a school conforming to all the standards fixed by the Medical Board, including instruction in the subject of materia medica, and in every other subject required for accreditation of a medical school; and,
>
> Second, that the applicant pass an examination given by the Board on all subjects on which they determine that applicants shall be examined.

"The Medical Board, under *House Bill 143*, which has passed the legislature, will consist of five doctors of medicine to be appointed by the governor, without limitation as to the schools of medicine from which the appointments may be made, one osteopath, and one chiropractor. That Board of seven members thus constituted would establish and determine whether osteopathic schools satisfied the standards to entitle their graduates to obtain certificates for licenses to practice osteopathy, medicine, surgery, and obstetrics. The law prohibits any discrimination. *Therefore, a failure on the part of the Board to require exactly the same standards of preparation for one group as would be required for another would be a failure to discharge its duties in accordance with the law.*"

The attorney of the state medical association also

has prepared the following statement indicating that this bill does not in any way change the status of the osteopaths in their relationship to hospitals:

"The osteopathic bill contains nothing pertaining to admission to practice in hospitals. The rights which private hospitals have always had, to make their own rules and regulations, continue entirely unchanged. The same laws regarding public hospitals, by which is meant hospitals supported in whole or in part by public funds, likewise remain unchanged. The governing boards of public hospitals retain the power conferred upon them by law to make rules and regulations, and that power is not limited or reduced by anything in the osteopathic bill. Neither is there anything in any other legislation that came from the recent session of the Indiana General Assembly that makes any changes in the rule-making power of the governing boards of the hospitals built and being operated under existing laws."

### INVESTIGATION OF THE INDIANA UNIVERSITY SCHOOL OF MEDICINE

Senator C. Omer Free, of Vincennes (Daviess and Knox Counties), introduced a resolution asking that an investigation be made to see if the Indiana University School of Medicine could admit and train more physicians. Following is the report of the commission as submitted to the Indiana General Assembly on February 28, 1945:

"The undersigned commission, appointed by the President of the Senate and the Speaker of the House, in accordance with Senate Joint Resolution No. 7 to make a thorough investigation of the Indiana Medical Center to see if more students cannot be graduated each year, hereby respectfully reports its findings and recommendations to the members of the Eighty-fourth General Assembly.

"Your committee respectfully reports that it has made an investigation to its satisfaction and that it has found that the Indiana Medical Center ranks sixth in the United States in the number of students graduated annually; that the facilities of said Indiana Medical Center for the education and training of medical doctors ranks far below sixth in the nation.

"Your committee further respectfully reports that with regard to facilities available with reference to laboratory space, equipment and staff, said Indiana Medical Center ranks first in the United States. Your committee further respectfully reports that it has been the policy of the Indiana Medical Center to not limit the number of students entering said school and to graduate as many medical doctors as is possible without lowering the standards of said school and with regard to the facilities available.

"Your committee further respectfully reports that the State of Indiana has not increased the number of medical students graduated in proportion to the increase in population, probably because Indiana has only one medical school compared with some neighboring states which have more than one, and further, because the facilities at the Indiana Medical Center have not been expanded within the last ten years or more.

"That it would not be expedient at this time to consider enlarging the facilities of the Indiana Medical Center because of the present national emergency, and because, further, the committee has found that the medical school has given to the war eighty-three members of its staff, and further that in all probability there will be a shortage of students within the next few years seeking admission because a large majority of that group is now serving in the armed forces of the United States.

"Your committee recommends that said Indiana Medical Center and its dean, personnel, and staff connected therewith be commended for their splendid record of service in maintaining said school upon a high standard, as it has in the past, which has merited high recognition in the nation.

"Dated this twenty-eighth day of February, 1945.

C. Omer Free (with reservations), *Chairman;*
Leo J. Stemle,
Samuel E. Johnson,
Leo A. Meagher,
Burt Summerland,
Katharine W. Atkins.
Members of the Committee."

### HOSPITAL COUNCIL MEASURE

A bill sponsored by the Indiana Hospital Association, creating an eight-member board to license, inspect, and regulate all regular hospitals, was among the most important measures enacted by the legislature.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Norman M. Beatty, M.D., } *Co-chairmen,*
J. William Wright, M.D., }
George Daniels, M.D.,
John Hewitt, M.D.,
J. R. Doty, M.D.,
M. R. Lohman, M.D.,
J. S. Niblick, M.D.,
Walter F. Kelly, M.D.,
Robert Acre, M.D.

### Bills Affecting the Medical Profession which Were Signed by the Governor and Became Laws

*S. B. 31*—Releases circuit court from issuing order declaring a discharged patient as sane after hospital superintendent has stated that a cure has been accomplished.

*S. B. 37*—Amendment to workmen's compensation law permitting the use of "spiritual means or prayer" as treatment for employee if desired.

*S. B. 84*—Nursing-home law.

*S. B. 89*—Sets fees for coroners in counties less than 100,000 population.

*S. B. 116*—Establishment of northern Indiana insane hospital.

*S. B. 182*—Creation of state department of veterans' affairs.

*S. B. 206*—Mental clinic hospital. Appropriates $250,000 for construction, and $75,000 for maintenance.

*S. B. 240*—Licensing of children's boarding homes and day nurseries.

*S. B. 241*—Provides that the governor has power to name heads of eleven institutions, and that trustees of nine institutions may name heads of those institutions.

*S. C. R. 16*—Urges Federal Government to establish three Veterans' Administration hospitals—at Gary, Fort Wayne, Evansville—and to increase capacity of present veterans' hospital in Indianapolis to one thousand.

*S. J. R. 8*—Investigation of the University.

*H. B. 9*—Education of patients in tuberculosis sanatoriums.

*H. B. 20*—Reorganization of county welfare boards.

*H. B. 22*—Three-member administrative state welfare board.

*H B. 24*—Insanity commitment bill, Marion County.

*H. B. 35*—Fort Wayne Board of Health pension bill.

*H. B. 46*—Dental hygienists bill.

*H. B. 65*—Licensing of maternity and nursing homes.

*H. B. 70*—Hospital boards to name treasurers.

*H. B. 73*—Board of Health bill for Indianapolis.

*H. B. 176*—Osteopathic bill.

*H. B. 143*—Modernizes Indiana State Board of Medical Registration and Examination.

*H. B. 180*—Narcotic definitions to include isonipecaine.

*H. B. 219*—Seven-man hospital board in counties of 18,000 and less than 19,500 population.

*H. B. 223*—Reissuance of professional licenses to returning service people without examination extended to July 1, 1947.

*H. B. 254*—Rehabilitation specialist on State Board of Vocational Education for deaf and hard of hearing.

*H. B. 304*—Amends occupational disease law to provide increase of death benefits and weekly benefits.

*H. B. 332*—Establishment of a laboratory for the diagnosis of animal diseases under the supervision of Purdue University.

*H. B. 391*—Appointment of lunacy commission.

*H. B. 411*—Riley Hospital part-pay patient bill. Amends law on admission of children to Riley Hospital to permit admission of those whose parents can pay part but not all of hospital expenses. This bill was opposed by the Indiana State Medical Association on authorization of the Council on the theory that the Riley Hospital was built to take care of charity cases only. Response, however, from the profession against the bill was not sufficiently general or enthusiastic to be effective. The faculty of the Indiana University School of Medicine was opposed to the bill as originally drawn, and upon its insistence the bill was amended so that the State Department of Public Welfare must make a statement as to what part is to be paid by the parents or guardians, and that no part-pay patients will be admitted as long as charity patients are on the waiting list.

*H. C. R. 1*—Noxious weeds.

**Vetoed by the Governor**

*H. B. 267*—Recommital of discharged inmates of schools for feeble-minded.

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# INDIANA HEALTH LEGISLATION A LA 1945

THURMAN B. RICE, M.D.*

INDIANAPOLIS

The Legislative Session of 1945 was characterized by the fact that the assembly seemed eager to pass the bills covering the constructive health program which was sponsored by Governor Gates and the Policy Committee. Every bill which had been suggested by the State Board of Health was passed, and in almost every instance unanimously. A few changes in these bills were made from the floor of the assembly, but in no case was the change serious to the original intent of the bill. This willingness on the part of the governor and the legislature is a strong vote of confidence, and lays a heavy responsibility upon the health authorities and the medical profession.

We shall attempt very briefly to review the most important of these bills. Of first importance is the arrangement to codify the health laws of Indiana. These laws are scattered through the law books since 1881 and are in great need of being re-written and re-arranged. This has been made possible by strengthening the Legislative Reference Bureau, which will assist us in this important work. Second, the reorganization of the State Board of Health will, we believe, serve as a stimulus to constructive thinking in matters pertaining to health.

* Acting State Health Commissioner.

As originally planned, we asked for a board of seven members. This request was modified from the floor, and as a result we shall have a board of nine members, of whom three will be physicians, one a dentist, one a veterinarian, one a pharmacist, one a sanitary engineer, one a nurse, and another who will probably be a lay woman. It may seem at first glance that the control of the board has been taken out of the hands of the medical profession, but we believe that such is not really true. In all probability the dentist and veterinarian will follow the professional line of thinking, as would also in all probability the other members of the board. We believe that the board as now constituted will actually be more health- and medically-minded than it has been in the past. It will also be free of the criticism that no one is represented except the medical profession, although obviously the health of the people is of concern to every group in the state.

Another bill sets up a State Health Council which will consist of twenty-five to forty-five members serving in an advisory capacity to the State Board of Health. This group will be able to bring reactions of the public to the board, and will be able to carry the message of the board back to their respective groups. It is expected that this council will consist of persons representing all of the important groups interested in health in the State of Indiana.

Other bills which were passed give more pay for the part-time health officers who have been notoriously underpaid in the past. Still another would permit the appointment of laymen to a position of health officer during the emergency when so many physicians are away.

A bill was passed permitting the various counties of the state to set up funds to which can be added gifts, donations, and bequests for the purpose of building local department-of-health buildings.

Hereafter the State Board of Health will be given the duty of surveying the state to determine where hospitals and health centers may be needed. Unless such a survey is favorable, the construction of such facilities will not be permitted. This bill is closely related to the one which empowers the Board of Health to license hospitals in the state. This latter bill was requested by the Hospital Association.

The uniform Vital Statistics Law, which will bring Indiana into harmony with most other states in the manner of recording births and deaths, was passed and should do much to relieve the confusion that has existed in these matters in recent years. Some half dozen other bills which are of importance were passed, but will only be mentioned. One requires that bread and flour be enriched with certain vitamins and minerals before being offered for sale. Another requires that cheese should be made from pasteurized milk, or should be either processed or aged at least sixty days before being sold. Another would set up a strong Department of Public Health in the Indiana University School of Medicine, for the purpose of giving postgraduate instruction to professional groups and short courses for non-professional groups. Another bill will require that all rules and regulations of the State Board of Health shall be rewritten, adopted by the State Board of Health, approved by the Attorney General, signed by the Governor, and promulgated by the Secretary of State. All of this will need to be done before January 1, 1946.

We believe that this session of the legislature begins a new era of health administration in Indiana. Governor Gates is to be congratulated on his farseeing policy in these matters. We feel deeply indebted to him and to the Legislature of 1945. He has consulted the Indiana State Medical Association at every turn, and has assured us that the welfare of the people of the state, from the standpoint of health, is a matter of first importance to him. It is by such means that we can convince the people of the state that we are doing something about the great demand for improved health. In this way we may hope to meet this demand without resorting to some form of federalized medicine.

### CALENDAR OF HEALTH BILLS PASSED

*H. B. 42*—Distribution of milk.

*H. B. 89*—Enrichment of bread and flour.

*H. B. 303*—Acceptance of gifts for county or city health departments.

*H. B. 306*—Public Health Advisory Council.

*H. B. 307*—Salaries of part-time health officers.

*H. B. 308*—Department of Public Health in the Indiana University School of Medicine.

*H. B. 311*—Employment of laymen as part-time health officers.

*H. B. 362*—Amend Act to establish a State Board of Health.

*H. B. 390*—Licensing, inspection, and regulation of all hospitals.

*H. B. 449*—Collection of Vital Statistics.

*S. B. 51*—Survey for acceptance of federal grants in regard to hospital and health facilities.

*S. B. 56*—Creates a State Administrative Building Council.

*S. B. 124*—Notifying County Health Officers of communicable cases of tuberculosis.

# Military News

Captain Mavor J. Moss, of Yorktown, has left Camp Croft, South Carolina, for an overseas station. He is on duty with a general hospital.

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Formerly at a general hospital with a San Francisco A. P. O. address, Major A. L. Arnold, of Indianapolis, has returned to this country, and is now at Camp Atterbury, Indiana.

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We note that Captain O. L. Meyer, of Portland, has been transferred from Sheppard Field, Texas, to the Regional Station Hospital at Patterson Field, Fairfax, Ohio.

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According to the *South Bend Tribune*, Captain George Colip, of South Bend, has been cited for his performance as the commanding officer of a hospital unit serving in Germany.

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Lieutenant William D. Hart, of Anderson, has been transferred to Camp Gordon Jolmston, of Carabelle, Florida. He was formerly stationed at the Lawson General Hospital, Atlanta, Georgia.

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With the headquarters of a bomber command, Major Joseph D. McDonald, of Evansville, has left Colorado Springs, Colorado, and is now in the Mariana Islands.

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A V-mail letter from Major Joseph C. Dusard, of Bedford, informs us that they have been in France for some time now, and have established their station hospital in an old French hospital. He writes that it is a fine place, and that they have been kept very busy.

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Captain Richard W. Holdeman, of South Bend, is with an evacuation hospital, and states that their work is much the same as it has been in the past—brain cases, soft tissue wounds, and splint cases. They receive wounded from the field hospitals, and in turn get them ready to send them farther back to a general hospital. Theirs is a tent hospital, as are a great many general hospitals.

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A recent letter informs us that Major Lionel H. Allen, of Bedford, has returned to this country and is assigned to the station hospital at the Presque Isle Army Air Base, Presque Isle, Maine. Major Allen has been attending the School of Aviation Medicine and AAF Tactical School at Randolph Field, Texas, and Orlando, Florida, but expected to return soon to Presque Isle, where he is currently assigned.

Major Edwin L. Libbert, of Lawrenceburg, now has charge of the X-ray Department at the Army Ground and Service Forces Redistribution Station at Asheville, North Carolina.

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Formerly at Camp Sutton, North Carolina, Lieutenant Leon Levi, of Indianapolis, has been transferred to Detachment of Patients, Lawson General Hospital, Atlanta, Georgia.

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Colonel Guy A. Owsley, of Hartford City, is stationed aboard a United States Army hospital ship in the Pacific area. Colonel Owsley was formerly the commanding officer of Billings General Hospital, Fort Benjamin Harrison, Indiana.

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Major Carl J. Rudolph, of South Bend, has been stationed in England, working in Nissen huts. During that time he has visited London, Liverpool, Manchester, Chester, and Birmingham. At the last report, however, it seems that he was seeing the inside of a hospital in France, being hospitalized with a combination of pneumonia and a sprained ankle.

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For the first time since 1940, Lieutenant Commander H. H. Slominski, of South Bend, spent the Christmas holidays with his family at his home in South Bend. The past three Christmases have been spent in the Pacific. Commander Slominski is now at the Naval Training Center, at Great Lakes, Illinois.

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According to a report which has reached our office, Major Merle E. Whitlock, of South Bend, escaped the German push by a matter of minutes, losing all his clothing with the exception of what he was wearing. He did manage to keep his camera with fifteen thousand feet of film, however; and, considering everything, personally felt very lucky. The hospital equipment of his unit was lost, but soon was replaced, and he is at work again.

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Now in Belgium, Captain William H. Lane, of South Bend, writes that while they were in France they were very busy, and saw some (although not a great deal) interesting surgery. He was, at the time the letter was written, getting the inevitable vacation that seems to be due prior to setting up another hospital. Major Lane wrote that Belgium is very interesting and that Brussels is a beautiful city. He adds that in Germany, too, he has seen some beautiful country, but has also seen considerable destruction there.

"The whims of the Army have brought me nearer home with my transfer to the laboratory of the Station Hospital at Fort Sheridan, Illinois," writes Captain Jean Pilot, a member of Lake County Medical Society. Captain Pilot is Chief of Laboratory, and was formerly stationed at Camp McCoy, Wisconsin.

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We are most happy to report that Lieutenant Harry Merrill Brown, of Cicero, was freed when the American Rangers took the Santos Tomas Prison Camp, on Luzon, in which he was held a prisoner. He has written his parents that he expected to be home before mail could reach him. Lieutenant Brown served his internship at the Indianapolis City Hospital, as did Captain Nelson V. Kauffman, of Indianapolis, who is still a prisoner of the "Japs." The two men were assigned to posts in the Philippines together, and were taken prisoner at the same time, but Captain Kauffman was removed to a Tokyo camp. His mother has received several cards from him, telling her not to worry, that he was as well as could be expected, and that he was currently caring for the sick and wounded among the prisoners in his camp. He has also been heard on Tokyo broadcasts.

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A V-mail from Major Charles P. Anderson, of Gary, has been received, and is quoted herewith: "Received the October JOURNAL the other day—about the only medical journal I've seen in six months. My address and rank have changed, which accounts for the delay. The promotion is recent—this month, in fact, and I am chief of the Division of Preventive Medicine, which means venereal and communicable diseases, sanitation of the messes and quarters, water supplies, et cetera, which is in line with my public health training and experience. Have been in Paris since September fifth—most of the time in unheated offices and billets, and am not too favorably impressed by the 'gay' city. I saw Lieutenant Colonel Booher, of Indianapolis, a month or so ago. He was stationed near, but has moved since. Regards to all."

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Captain George Godersky, of Indianapolis, a graduate of the Indiana University School of Medicine, is one of the "medics who is doing a wonderful job" with an infantry division in Luxembourg, according to an Associated Press dispatch. When a squad was pinned down by German fire in an open field, a smoke screen was laid with mortar shells to get out the wounded. Even then the medics were driven back once before they could evacuate them all. The dispatch quoted Captain Godersky, who is a battalion medical officer, as stating that although the men are not comfortable or warm they know how to avoid frostbite, and that the number of respiratory troubles has been surprisingly small. Captain Godersky entered the Army in July, 1943, after completing his internship at the Indiana University Medical Center.

Captain Don E. Kelly, of Indianapolis, has written: "I have pretty much the same setup here as at home, but in a rather crude style, and a one-man stand. I've seen Captain Arbuckle on two trips, and he is the same old guy, less thirty pounds. He is doing a swell job, and deserves a great deal of credit. Best of luck, and good wishes to all."

*Captain Don E. Kelly*

Captain Kelly is on duty with a station hospital in Italy.

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Captain Eugene Weiss, of South Bend, is working for a combined Air Force clearing station and field and station hospital. He is established in one of the most modern hospitals in France, and states that it is equipped with "more built-in gadgets all over the place" than he has ever seen before. Captain Weiss reports that all they have to do is to push a button for each disease, and the bugs get well. (We venture to say that Captain Weiss, and a lot of others, will add some worth-while contributions to our medical lore after the war.)

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Lieutenant Commander W. J. Stangie, of Mooresville, writes: "A few days ago I received my November issue of THE JOURNAL. It had made a round trip to New Guinea and back to Washington. I enjoy reading THE JOURNAL, and especially did I enjoy the candid camera shots of Vern Hahn, Bert Ellis, Nafe, Batman, Bob Moore, "The Magic" Collins, and Solomon.

"I am located back in the U. S. A. after nineteen months in the Southwest Pacific area. Best regards to all my professional friends back there." Commander Stangle is now at the Naval Barracks in Bangor, Washington.

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Lieutenant Colonel Harold J. Halleck, of Winamac, has written the following letter from Luxembourg:

"As division surgeon, I feel a grave responsibility toward forty-four doctors who have not seen an operation in six months of combat service, let alone perform one. Most of them are older men, too, and in spite of all my efforts and pleading, not one of them has as yet been rotated to a professional assignment. One of my battalion surgeons recently made the statement that the only way to get out of his job was to go out feet first. Two of ours have gone out that way because of wounds, and one because of illness. One other got into hospital work by the simple expedient of being captured by the enemy.

"Don't misunderstand me, the boys here take it and like it, but all of us get exceedingly tired of the praise for the rear echelon medicos who stand so much hardship and danger."

Stationed at a naval training station, in Virginia, Lieutenant Commander William E. Miller, of South Bend, is senior officer in an eye, ear, nose, and throat department. He is living in a trailer in a patch of woods along the shore of an arm of the Chesapeake Bay. Commander Miller finds the trailer quite comfortable, and that it easily surpasses the jungle of the New Hebrides.

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Captain Harry G. Rotman, of Jasonville, is serving as ward officer with a station hospital, which in twenty months of overseas service has treated approximately fifteen thousand patients while operating in Algeria and Tunisia, and during its present tour of Italy. Upon moving to Italy the unit members earned their first Bronze Star by opening their hospital on an important communication line behind the front. Captain Rotman has been overseas since May, 1943.

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Now medical officer aboard a destroyer, Lieutenant Joseph R. Fouts, of English, has received an official commendation from Admiral Harold R. Shark, United States Naval Commander of the United States Naval Forces in Europe. The text of the letter from Admiral Shark follows:

"Your performance of duty as medical officer of the U. S. S. ——, during the invasion of France, June 6, 1944, has been brought to my attention. Your devotion to duty and application of technical skill was responsible for the saving of the life of a badly-wounded man in spite of the distractions of the firing of the ship's guns during bombardment. Five wounded men brought aboard the U. S. S. —— by a LCVP (Landing Craft, Vehicle, Personnel) were treated efficiently and with untiring patience.

"For your professional skill and your devotion to duty you are hereby commended."

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From the Dutch East Indies, Captain Voris F. McFall, of Anderson, has written as follows: "This is to inform you that I am now a commissioned officer in the Regular Army, Medical Department, A. S. N. 26992. I imagine that of all the Hoosier medicos inducted in the Indiana 'Blitzkrieg' of 1942, there are very few of us who are now in the Regular Army to stay. So, in your postwar plans for Indiana you can hereby drop me from the rolls.

"I wouldn't be at all surprised that in the near future you will hear from numerous other younger Hoosier medics to the effect that they are staying in the Army or Navy—if necessary, at the request of Uncle Sammy.

"I haven't had contact with any Hoosier boys in some months—so have no news to tell you. "Doc" Cook, of North Manchester, left this morning on a rest leave to Sydney. He's with a bombardment squadron in our group.

"THE JOURNAL is still coming; thank you so much—it is certainly appreciated."

A letter from Captain J. A. Torrella, of Indianapolis, tells us that he is with a general hospital located in Paris.

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Lieutenant Colonel Charles F. Thompson, of Indianapolis, who is with the Indiana General Hospital, has written a most interesting letter to *The Bulletin* of the Indianapolis Medical Society. We have been so eager to hear from our Indiana General Hospital that we asked *The Bulletin's* permission to quote it in part:

"Actually the longer one is in the game, the less one attempts to picture the thing for others. That happened to most of us back at Bowie. We sailed through our training period and liked it. Trained a good group of GI's in the manner and means of the way we anticipated running a hospital. Then we were on our way, rejoicing. There wasn't much news except that we were so anxious to work that publicity became a hazard.

"In England—I shall refer to it as the O. K.—we dropped in on a good Mission Hut Hospital, which interestingly enough had been earmarked with our hospital number for more than a year. It was not entirely completed before we had patients to care for. It was on the estate of an old country place on the bank of the Colne River. Cy Clark and one-third of the personnel were opening up a smaller hospital and ran it for four months, only twenty-five miles away.

"We did good work and were recognized for it. We considered ourselves one of the old guard of general hospitals in the O. K.—among the first seven—and have maintained ourselves on the batting list since that time. Cy became C.O. in February, and we turned over the place on the Colne to a newly-arrived group about the first of May. Then there was a three-month coasting period before Normandy. It was spent in an area resembling French Lick—tennis, golf, some bridge and always out-of-doors. Nice people, and we made many permanent friends. There were tennis tournaments with the RAF—backhand as she is done by the British—competitive contests, duals and so forth.

"Then we were off for Normandy, still in the vanguard of general hospitals, because we had proved ourselves as able. We set up in the dust, and then existed in mud for thirteen weeks. Our hospital, this time under canvas, was prepared by the Army Engineering Corps in two weeks, and the war was quite near. But it moved on from us. We did a tremendous amount of work in those weeks—were a link in the chain of evacuations, returning about half our casualties to duty of some kind by surgery, medical care, or food and rest. Always there were two-thirds to three-fourths surgical cases. Penicillin and sulfa were our anchors.

"Now we are in the war again, in Belgium, to be placed again in a key position, and soon, I hope.

"We have lost personnel by transfer (always over our objections) because our specially trained men looked very good in advanced positions in other units. Caseley, Bill Norman and Fred Reynolds, all orthopedic surgeons, head sections. Pilcher, Leffel and Megenhardt, all general surgeons, have become chiefs of surgical services.

Young George Clowes and Speas, from Bloomington, went to combat units in the Army Medical Corps. Kwitney and Paul Fouts are both chiefs of services in other general hospitals. Three nurses have gone out to be in charge of services.

"So there you are. Not one left except with regrets and objections. We have some replacements, and will do the job still ahead of us with our best, and like it. At present we are standing by, to move again into a key position, with much anticipation. We are in a nice hotel; have rid ourselves of the mud; have come to know the war, and have acquired a viciousness toward the enemy that combat units have after seeing and hearing what has been done by a ruthless mob."

# POSTWAR HAPPENINGS TWENTY-FIVE YEARS AGO

(Items from THE JOURNAL of April, 1920)

The scientific section carried the following articles: "Hour Glass Bladder," by H. K. Bonn, of Indianapolis; "Resumé of Past Two Years' Prostatic Work," by W. N. Wishard and H. G. Hamer, of Indianapolis; "Renal Tuberculosis," by P. E. McCown, of Indianapolis; and "Testing Kidney Function," by A. C. Yoder, of Goshen.

* * *

The editor gave an extended comment on the treatment of diphtheria, urging that the Schick test be used more widely by general practitioners.

He also directed the attention of ex-medical officers to the fact that the Indiana Historical Commission was compiling what they hoped would be a complete record of every medical man who had served in World War I.

* * *

Comment was made on the work done at the Rockefeller Foundation and Rockefeller Institute, chiefly by Noguchi, in the study of yellow fever. Doctor Noguchi had spent considerable time in Ecuador and in Yucatan, studying the disease, and his further investigation was made along the lines of his observations of the disease in those countries.

* * *

General Leonard A. Wood, at that time a candidate for the Republican nomination of President, had come out with a declaration in favor of the establishment of a National Department of Health, with a medical man as its head, he to be a member of the President's Cabinet.

* * *

The editor commented on a verdict of $5,000 for damages sustained by an individual who had been struck by an automobile, urging that all who were driving cars avail themselves of the proper liability insurance.

* * *

Complaint was again made that while in other states vigorous prosecution of violators of the medical practice acts were being made, our Indiana board was sitting supinely by, doing nothing about it. (This was one of editor Bulson's pet peeves, and he aired his "grievances" on each and every occasion.)

* * *

The practice of health officers, of charging for various certificates, was declared illegal.

According to current newspaper reports, the principal of Shortridge High School, at Indianapolis, had issued an order forbidding girl students in that institution to wear silk stockings while in school. The official stated that the ban would be removed after the epidemic of influenza had subsided.

* * *

Politics had again invaded the office of the Indiana State Board of Health, and it was rumored that efforts were being made to "get rid of" Dr. J. N. Hurty, the secretary, and his assistant, Dr. William F. King.

* * *

A warning was issued to the effect that at the 1921 session of the Indiana General Assembly a prodigious effort would be made by the chiropractors to gain official recognition. (After twenty-five years they are still at it!)

* * *

The editor reported that another measure likely to come up at the same session was that of compulsory health insurance.

* * *

The Mudlavia Springs Hotel and Sanitarium, near Attica, had been destroyed by fire.

* * *

Blackford County residents had voted in favor of building a county hospital, at Hartford City.

* * *

Gary physicians had announced a step-up in their fee-schedule.

* * *

Dr. Hugh S. Cumming had been named to succeed Dr. Rupert Blue as Surgeon-General of the United States Public Health Service.

* * *

A hospital staff was formally organized at Holy Family Hospital, at LaPorte.

* * *

The Calhoun County (Michigan) Medical Society had passed a resolution permitting membership to American citizens only.

* * *

The Irene Byron Hospital, at Fort Wayne, had planned three additional wings, accommodating ninety more patients.

## A LIFT

To avoid the painful strains, sprains, and hernias caused daily in plants throughout the nation by incorrect lifting of weights, workers should remember and practice the following rules:

(1) Feet about twelve inches apart, adopt a stance which is comfortable and will enable you to lift as nearly straight up as possible; (2) keep your back straight, get down by *bending your knees,* and raise the object by straightening your legs. Women who find this stance uncomfortable should try getting down on one knee to handle the object, but the actual lifting should still be done by straightening the knees, throwing the brunt of the strain on leg and shoulder muscles.—*The Continental*—December, 1944.

# Deaths

**Godlove Grover Eckhart, M.D.,** of Marion, died February twenty-sixth, at the age of sixty-two. He was a graduate of the Jefferson Medical College, of Philadelphia, in 1907, and limited his practice to surgery. He was a member of the Grant County Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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**Charles Emery Burleson, M.D.,** of LaPorte, died February tenth at his home. He was a graduate of Northwestern University School of Medicine, in 1904, and had practiced medicine in LaPorte for forty years. Doctor Burleson was especially interested in pediatrics. He was a member of the LaPorte County Medical Society, the Indiana State Medical Association, and the American Medical Association.

**Brose Sumerville Horne, M.D.,** of Gas City, died February twelfth, at the age of seventy-one. He was a graduate of the Medical College of Ohio, in Cincinnati, in 1895.

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**Henry Jefferson Defrees, M.D.,** of Nappanee, died of a heart attack at his home on February sixth. Doctor Defrees was a graduate of the Rush Medical College, in 1888, and had practiced almost half a century at Nappanee. He was eighty-three years of age and had retired in 1939. In addition to his medical practice, Doctor Defrees was very active in community affairs, and had served one term as mayor in 1936. He was a member of the Elkhart County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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# News Notes

As a recent meeting, Dr. H. M. English, of Gary, was elected as president of the Gary Board of Health. He succeeds Dr. B. W. Harris.

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Dr. E. G. Bounnell has closed his office at Veedersburg, but will continue practice from his office in Hillsboro. For the past several years Doctor Bounnell has maintained offices at both places.

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Dr. Dillon D. Geiger, of Bloomington, has received a discharge from the Army Air Corps, and has reopened his office in Bloomington. Dr. Geiger will limit his practice to medical and surgical diseases of the head and neck.

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### AMERICAN PHYSICIANS ART ASSOCIATION

There will be no annual exhibit this year of the American Physicians Art Association, due to the cancellation of the American Medical Association meeting which had been scheduled to take place in Philadelphia, June 18-22, 1945.

However, the art contest, sponsored by Mead Johnson & Company, on the subject of "Courage and Devotion Beyond the Call of Duty" (on the part of physicians) has not been cancelled or postponed. The closing date remains May 27, 1946.

For full details regarding the thirty-four thousand dollar prizes and the "Courage and Devotion Beyond the Call of Duty" contest, write Dr. Francis H. Redewill, Flood Building, San Francisco, California.

Dr. Richard J. Reynolds has opened an office in Salem for the practice of medicine. He is a graduate of the Indiana University School of Medicine, and recently completed his internship at the Medical Center in Indianapolis.

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### INDUSTRIAL HEALTH CONFERENCE CANCELLED

As a measure of cooperation with the Office of Defense Transportation in its effort to cope with the present emergency in hotel and transportation facilities, the Third Annual Indiana Industrial Health Conference will *not* be held this year.

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It has been announced that Dr. Robert J. Jermstad, of Fort Wayne, has severed his connection as pathologist at the Fort Wayne Medical Laboratory and the Lutheran and Methodist Hospitals, to become pathologist at the Hurley, St. Joseph's and Women's Hospitals at Flint, Michigan.

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### AMERICAN PSYCHIATRIC ASSOCIATION CONVENTION CANCELLED

The American Psychiatric Association, the oldest medical society in America, has announced the cancellation of their 101st annual meeting, which was to have been held in Chicago in May of this year. It was the feeling of the association that it would be the duty of the membership to fall in line with the request of the United States Government to cancel conventions in the spirit of the war cooperation.

Dr. H. D. Hill and Miss Marjorie Ellen McCain, both of Richmond, were married at the Central Methodist Church in Richmond, on Sunday, February eleventh. Dr. Hill has been a practicing physician at Richmond for several years.

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Dr. Robert M. Maurer, who graduated from the Indiana School of Medicine in 1942 and who has just completed his internship at the Indiana University Medical Center, has located at Brazil for the practice of medicine.

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Dr. Murray N. Hadley, of Indianapolis, has been appointed by Dr. N. K. Forster, the president of the Indiana State Medical Association, as a representative of the state association upon the Indiana Traffic Safety Council. This council was organized in 1938 and has rendered valuable support to the cause of traffic in our state. Paul G. Hoffman, the president of the Indiana Traffic Safety Council, has reported that the Council's Executive Board is planning to expand the activities of the Council, in order to be in a position to help cope with the post-war traffic situation, which many believe will eclipse in magnitude anything previously experienced.

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**RADIO CALENDAR**

"YOUR HEALTH IN WARTIME"

Hear these broadcasts each week:

Indiana State Medical Association—Doctor Goodhealth—Monday, 3:30 P.M., WFBM, Indianapolis

Elkhart County Medical Society—Wednesday, 4:30 P.M., WTRC, Elkhart

Vigo County Medical Society—Thursday, 12:15 P.M., WBOW, Terre Haute

St. Joseph County Medical Society—Friday, 1:45 P.M., WSBT, South Bend

Howard County Medical Society—Friday, 6:30 P.M., WKMO, Kokomo

Vanderburgh County Medical Society—Saturday, 10:00 A.M., WGBF, Evansville

## INDIANA UNIVERSITY NEWS NOTES

The Indiana University School of Medicine was given commendation for its "splendid record of service" in a report made recently to the Indiana General Assembly by a special legislative investigating committee, representing the two houses of the General Assembly. The university's medical school was declared by the report to rank sixth in the country, in point of annual number of grad-


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GYNECOLOGY—Two Weeks Intensive Course April 23, June 18. One Week Personal Course Vaginal Approach to Pelvic Surgery May 21, July 9.

OBSTETRICS—Two Weeks Intensive Course April 9, June 4.

ANESTHESIA—Two Weeks Course Regional, Intravenous & Caudal Anesthesia.

ROENTGENOLOGY—Courses in X-Ray Interpretation, Fluoroscopy, Deep X-Ray Therapy every week.

UROLOGY—Two Weeks Course and One Month Course every two weeks.

CYSTOSCOPY—Ten Day Practical Course every two weeks.

ELECTROCARDIOGRAPHY & HEART DISEASE — One Month Course starting May 7. Two Weeks Intensive Course starting August 6.

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uates. In regard to facilities available with reference to laboratory space, equipment, and staff it ranks first in the United States. The report was signed by all members of the committee, consisting of Senators C. Omer Free, of Vincennes; Samuel E. Johnson, of Anderson; Leo J. Stemle, of Jasper; and Representatives Katherine E. Atkins, of Indianapolis; Leo R. Meagher, of Evansville; and Burt Summerland, of Wabash.

The resolution under which the inquiry was made stated that the Indiana University School of Medicine "has for some years been limiting the number of students" so that "for some years past, even before the war, there was a scarcity of medical doctors in the state." The committee after its inquiry found, however, that "it has been the policy of the Indiana Medical Center not to limit the number of students entering the school, but to graduate as many medical doctors as possible without lowering the standards of the school, with regard to the facilities available."

The committee's report further declared:

"That the State of Indiana has not increased the number of medical students graduated in proportion to the increase in population, probably because Indiana has only one medical school compared with some neighboring states which have more than one, and, further, because the facilities at the Indiana Medical Center have not been expanded within the last ten years or more.

"That it would not be expedient at this time to consider enlarging the facilities of the Indiana Medical Center because of the present national emergency, and because the committee has found that the medical school has given to the war eighty-three members of its staff, and, further, that in all probability there will be a shortage of students seeking admission within the next few years since a large majority of that group is now serving in the armed forces of the United States."

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Twenty-six students of the Indiana University School of Medicine achieved distinction last year in writing medical articles, according to an announcement by Dean W. D. Gatch. Those recognized for their writing, which Dr. Gatch has declared to be an essential part of the training of doctors, included the following:

Junior surgery papers—Melvin A. Block, Evansville; Justin E. Arata, Mishawaka; Geraldine M. Zix, Indianapolis; Morris Green, Indianapolis; Donald L. Trinosky, Indianapolis; Charles G. Smith, Indianapolis; Frederick G. Green, Fort Wayne; Willard A. Scantland, Richmond; Paul M. Dassel, Evansville, and William R. Noe, Indianapolis.

Sophomore bacteriology papers — Robert Bartlett, Bloomington; W. C. Robertson, Indianapolis; Paul S. Jarrett, Sharpsville, and William J. Miller, Fort Wayne.

Sophomore history of medicine papers—Joseph V. Schetgen, New Castle; William G. Bannon, Kokomo; Robert W. Harger, Indianapolis; Floyd B. Coleman, Martinsville, and J. Martin Miller, Indianapolis.

Senior medicine papers—Ben Wilson, Bloomington; Rex Huff, South Bend; Carolyn Rawlins, Hammond; Harold Tharp, Trafalgar; Norris Knoy, Paragon; Robert Lloyd, Fort Wayne, and George Westfall, Goshen.

Students writing the junior and sophomore papers have received the annual Osterman Awards, on the basis of selections made by the editorial board of the *Quarterly Bulletin* of the Indiana University School of Medicine.

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# Society Reports

## 100% IN PAYMENT OF 1945 DUES

HARRISON COUNTY
PIKE COUNTY
PUTNAM COUNTY
MADISON COUNTY

## COUNTY MEDICAL SOCIETY OFFICERS

**MIAMI COUNTY MEDICAL SOCIETY**
President, F. M. Lynn, Peru
Vice-president, J. E. Yarling, Peru
Secretary-treasurer, E. Lee Burrous, Peru

**VIGO COUNTY MEDICAL SOCIETY**
President, Noel S. McBride, Terre Haute
Vice-president, Robert R. Brown, Terre Haute
Secretary-treasurer, A. M. Mitchell, Terre Haute

**CLAY COUNTY MEDICAL SOCIETY** members held a meeting at the Clay County Hospital, at Brazil, on March thirteenth. The speaker was Mr. Joe Weinland, a member of the Pharmacy Board, who discussed "Prescribing of Restricted Drugs." The members had invited the nursing staff as their guests.

**DEARBORN-OHIO COUNTY MEDICAL SOCIETY** members met at the public library, in Aurora, on February twenty-second. Dr. G. S. Fessler, of Rising Sun, presented a paper entitled, "Treatment of Stricture of Cardiac Orifice of Stomach." Five members were present.

**DELAWARE-BLACKFORD COUNTY MEDICAL SOCIETY** members met at Hotel Roberts, in Muncie, on February twentieth. The meeting consisted of reports of committees and discussion of local and state legislative matters. There was also a discussion of the St. Paul-Mercury Indemnity Company malpractice insurance policy. Twenty-nine members attended the meeting.

**ELKHART COUNTY MEDICAL SOCIETY** members met at Hotel Elkhart, on February first. The speaker was Dr. William D. Paul, assistant professor of medicine at the University of Iowa, whose subject was "Infectious Mononucleosis." Thirty-eight members were present.

At another meeting on March first, Glenn L. Jenkins, Ph.D., dean of the school of Pharmacy at Purdue University, spoke to the thirty-two members present. His subject was "Recent Advances in the Pharmaceutical Field of Interest to the Medical Profession."

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# SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

**GREENE COUNTY MEDICAL SOCIETY** members met at the Roosevelt Hotel, in Linton, on March fifteenth, as dinner guests of Dr. George C. Porter. The meeting was devoted to a discussion of current business matters. Ten members were present.

**HOWARD COUNTY MEDICAL SOCIETY** members held a meeting at the St. Joseph Memorial Hospital, on March second. Dr. Thurman B. Rice, of Indianapolis, spoke on "Undulant Fever." The members invited a number of veterinarians to this meeting, and eighteen members and guests were present.

**HARRISON COUNTY MEDICAL SOCIETY** members were entertained with a dinner, by Dr. and Mrs. W. E. Amy, of Corydon, on February eighth. Following the dinner a business meeting was held. Seven members were present.

**HUNTINGTON COUNTY MEDICAL SOCIETY** members met at Huntington, on March sixth. The speaker at this meeting was Dr. E. J. Teeter, of Indianapolis, who discussed "Diagnosis, Management, and Treatment of Anemias." Seventeen members and guests were in attendance.

**INDIANAPOLIS (MARION COUNTY) MEDICAL SOCIETY** members met on March sixth at the Indianapolis Athletic Club. Drs. John W. Hendricks, Don Bowers, John Heubi, and Gail Eldridge, all of Indianapolis, presented case reports.

The March thirteenth meeting was held at the Veterans' Hospital, the program consisting of the following papers: "Organization and Function of the Medical Activities of the Veterans' Administration," by Lieutenant Colonel Earl H. Hare; "Subastragaloid Dislocation—Two Cases of Osteoid-Osteoma," by Captain Henry J. Nowak; "Glomus Tumor," by Lieutenant Colonel Victor F. Tremor; "Some Aspects of Cardiology as Seen in a Veterans' Hospital," by Captain Louis M. Sales; and "Hypoparathyroidism Postoperative," by Lieutenant Richard A. Loomis.

At another meeting held March twentieth, Dr. Lawrence W. Nehil presented a paper on "Treatment of Bronchiectasis and Lung Abscess," which was discussed by Dr. Marlow Manion. Dr. Harold M. Trusler presented a paper on "Management of Neoplasms of the Head and Neck," which was discussed by Dr. Lester A. Smith.

On March twenty-seventh the program was presented by the staff of the Indiana University Hospital in the Medical School auditorium.

**LAPORTE COUNTY MEDICAL SOCIETY** members met on February fifteenth at the Rumeley Hotel, in LaPorte. The guest speaker was Dr. Eric Oldberg, of Chicago, whose subject was "Spinal Cord." Twenty members attended the meeting.

At another meeting on March fifteenth, the speaker was Dr. Chauncey C. Maher, of Chicago, who discussed "The Complications of Coronary Heart Disease." The talk was followed by a short business meeting. Fourteen members were present.

**LAKE COUNTY MEDICAL SOCIETY** members held a meeting on February eighth at the St. Mary's Mercy Hospital, in Gary. Dr. Thomas R. Ponton, of Chicago, spoke on "Hospital Staff Organization and Professional Service Accounting." Approximately fifty members were present.

At another meeting on March eighth, Dr. David R. Johns, of East Chicago, spoke to the fifty members present, on the subject "Aluminum Therapy in Silicosis." This meeting was held at St. Margaret's Hospital, in Hammond.

**MONTGOMERY COUNTY MEDICAL SOCIETY** members met at the Culver Hospital, in Crawfordsville, on February fifteenth. The speaker for this meeting was Dr. George A. Collett, of Crawfordsville, who discussed "Fluid Balance and Acid-Base Regulation." Twelve members and guests attended the meeting.

**PARKE-VERMILLION COUNTY MEDICAL SOCIETY** members met at Clinton, on January seventeenth. The guest speaker for this meeting was Dr. Kenneth G. Kohlstaedt, of Indianapolis, who discussed "Hypertension." The talk was followed by a discussion by the six members present.

**MIAMI COUNTY MEDICAL SOCIETY** members met at Peru on February twenty-third for a business meeting. Seven members were present.

**RUSH COUNTY MEDICAL SOCIETY** members met at the Lollers Hotel, at Rushville, on February fifteenth. The guest speaker for this meeting was Captain Donald I. Dean, M.C., of Rushville. Nine members were present.

**ST. JOSEPH COUNTY MEDICAL SOCIETY** members held a meeting at the Indiana Club, at South Bend, on March thirteenth, to hear Dr. Agatha M. Wilhelm, of South Bend, who discussed "Aortic Stenosis." Thirty-four members and guests were present.

**SPENCER COUNTY MEDICAL SOCIETY** members held a meeting at Rockport, on January twenty-fourth, for the discussion of current business matters.

**WAYNE COUNTY MEDICAL SOCIETY** members met at a joint meeting with the Richmond Personnel Association, at the Perfect Circle Plant, at Richmond, on February fifteenth. The speaker was Dr. Emmett B. Lamb, of Indianapolis, who spoke on industrial neurosis and industrial insurance.

**VANDERBURGH COUNTY MEDICAL SOCIETY** members held a meeting on February thirteenth, at Hotel McCurdy, in Evansville. The speaker for this meeting was Keith S. Wilson, M.D., of St. Louis, Missouri, who presented a paper on "Some Clinical Experiences with Penicillin." Forty-five members and guests attended the meeting.

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IN-4-45

## *WOMAN'S AUXILIARY to the Indiana State Medical Association*

**President—Mrs. F. M. Gastineau, Indianapolis**
**President-elect—Mrs. S. J. Petronella, East Chicago**
**Corresponding Secretary—Mrs. C. L. Bock, Indianapolis**
**Treasurer—Mrs. A. W. Ratcliffe, Evansville**
**Press and Publicity—Mrs. A. B. Richter, Indianapolis**

### WOMAN'S AUXILIARY

Board Meeting—April 25th at the Indianapolis Athletic Club
Dinner at 6:30 p. m.

Convention of the House of Delegates, April 26th
At the Columbia Club, at Indianapolis
10:00 a. m. Business session. Mrs. F. M. Gastineau, presiding.
12:30 p. m. Luncheon.
1:30 p. m. Business session continued.

### ALLEN

Mrs. H. O. Bruggeman was hostess to the Allen County Medical Auxiliary, which met at 8:00 P.M., February thirteenth, at her home. Mrs. Arnold H. Duemling was elected an honorary member, on the basis of her outstanding work in the state and for the office she holds in the national organization.

Technical Sergeant William B. Rider, a member of the Army Air Forces who spent approximately two years overseas and wears three battle stars, told of his experiences in England, Africa, and Italy.

### CLARK COUNTY

Mrs. C. F. C. Hancock was recently elected president of the Clark County Auxiliary. The group held a luncheon meeting. During the business session plans were made for the auxiliary to entertain the Nurses' Aides of the Clark County Memorial Hospital at a tea in February.

### FLOYD

A luncheon meeting was held for fourteen members at the home of Mrs. J. E. Bird, in New Albany, on January twelfth. Mrs. A. M. Baker, president, presided at the business meeting, at which time subscriptions to *Hygeia* were given to the Senior and Junior High Schools, the Scribner School, the Public Library, and the Holy Trinity Parochial School.

Mrs. C. E. Briscoe entertained the Floyd County Auxiliary at her home on February ninth, at 7:30 P.M.

### HOWARD

On February second, Mrs. R. P. Schuler entertained the Auxiliary at her home. The program was in the charge of Miss Lucy Schuler.

Bills introduced at the present session of the state legislature, as pertaining to health and public welfare, were read by Mrs. W. F. Tranter. Seventeen members were present at this meeting.

### LAKE COUNTY

The Woman's Auxiliary to the Lake County Medical Society consists of three branches, and the following are news items from all. The Hammond Branch sent sixteen *Hygeia* subscriptions to the Wakeman General Hospital, at Camp Atterbury, besides contributing complete files of several other magazines. They also met at the home of Mrs. N. K. Forster, on January third, where they made candy to be sent to the hospital.

The Gary and South Branch donated boxes of Christmas cards for the men to send out, also magazine files and books for the library at the hospital. Mrs. H. M. Baitinger, of Gary, is the County Red Cross chairman for obtaining gifts for the Wakeman General Hospital. Under her inspiration auxiliary members have been instrumental in getting other women's groups to which they belong interested in donations for the hospital and the wounded men there. At the January meeting of this branch of the auxiliary Mrs. J. W. Mather, of East Gary, showed pictures and told about the topography and the people of the Philippine Islands. She formerly resided with her husband in the islands. To coincide with the state and county auxiliary elections, this group postponed its elections until next month.

Mrs. J. W. Mather and Mrs. R. M. May, of Gary, were guests at a luncheon of the Auxiliary to the Cook County Medical Society, held in the Medinah Club, at Chicago. Mrs. Mather brought greetings from Indiana, as visiting State Public Relations chairman.

The East Chicago-Whiting Branch met in January at a reorganization tea. Mrs. T. F. Cotter was elected chairman of the group. They are making service kits for the Wakeman Hospital.

On Wednesday, February seventh, the Auxiliary board members, and other qualified members, met in an all-day session at the home of Mrs. R. M. May, in Gary, for the purpose of revising its constitution to make the year conform with that of the state and national organizations. By-laws were added to more specifically define duties of officers and committee chairmen. The regular February meeting of the county auxiliary met in Gary on the evening of February tenth in Mrs. May's home. The first reading of the new constitution was given, and suggestions from the general group were accepted. The nominating committee for the county will give a report at the March meeting. The local groups have elected the following chairmen:

East Chicago—Whiting Branch: Mrs. T. F. Cotter.
Hammond Branch: Mrs. M. B. Gevirtz.
Gary—South Branch: Mrs. Carl H. Bendler.

At the February meeting of the Hammond Branch, Mrs. Edna Dycus, Probation Officer for the Juvenile Court, spoke on "How Lake County Copes with the Juvenile Problem of Today."

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### MARION COUNTY

Mrs. Henry S. Leonard, president of the Marion County Auxiliary, presided at the January meeting, which was held at the Indianapolis City Hospital. Mrs. Lester A. Smith, legislative chairman, was in charge of the program. Mr. Thomas Hendricks, executive secretary of the Indiana State Medical Association, gave an informal but very informative talk on "Bills Before the Federal and State Legislature." The bills discussed pertained to medicine and group insurance. Interest was shown by the many questions asked by the audience following Mr. Hendricks' discussion.

Mrs. Lawrence Nehil, a member of the *Hygeia* committee, reported that Marion County had obtained approximately eighty subscriptions to the magazine. The Auxiliary voted to give five subscriptions to local community recreation centers. Tea was served in the nurses' dining room following the meeting.

On March fifth approximately three hundred members and guests of the Marion County Auxiliary met at 2:00 P.M., in Block's Auditorium, to hear Dr. A. F. Weyerbacher and Mrs. James L. Bradley discuss the problem of juvenile delinquency. Mrs. Emmett B. Lamb, public relations chairman, had charge of the program. Mrs. Henry S. Leonard, president of the Marion County group, presided at this open meeting.

Dr. A. F. Weyerbacher had as his topic "Adult Health and Its Relation to Juvenile Delinquency." He quoted former President Hoover's statement that "Human progress marches only when children excel their parents." "In order to attain a satisfactory situation in regard to adults' health," he said, "it is often necessary to provide a place for children to amuse themselves in housings other than their own homes. Contrary to popular impression, I believe we can agree that juvenile delinquency is not a greater social threat because of the war. The pathology which the professional recognizes under the term juvenile delinquency has been mounting in seriousness each year, and now in the white incandescense of war has reached the laity." He pointed out that the various agencies, police, social workers, courts, and churches, along with the public, have tried to face the situation fairly.

Mrs. James L. Bradley, referee of the Marion County Juvenile Court, had as her subject "Youth Steps Out." Mrs. Bradley gave the history of the juvenile court, which was founded in 1903. She also gave several case histories of young people who had been brought into court, and pointed out that the same causes which prevailed in 1903 still prevail—i.e., poverty, ignorance, broken homes, and lack of discipline.

### MARSHALL COUNTY

On January third members of the Marshall County Auxiliary met for a luncheon in Plymouth. Mrs. M. O. Klinger presided at the business session, after which Mrs. C. R. Graham, of Bourbon, reviewed "Shark's Fins and Millet," by Ilona Ralf Sues.

### ST. JOSEPH

Mrs. R. W. Spenner, of South Bend, was hostess to the St. Joseph County Auxiliary at her home on February ninth. The group met at 1:30 P.M., and dessert was served. The program was presented by the Central Senior High School Glee Club.

### VIGO COUNTY

Fifty-five members and guests of the Vigo County Auxiliary attended the annual dinner meeting held January ninth at the Woman's Department Club. Mrs. C. R. LaBier presided and welcomed the guests. Mrs. Floyd Riggs reported on twenty-six gift subscriptions to *Hygeia*. Mrs. C. N. Combs, chairman of the program committee, introduced Mrs. Arthur Cunningham, who reviewed "The Immortal Wife," by Irving Stone.

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### DIVISION OF COMMUNICABLE DISEASE CONTROL

**Monthly Report—January, 1945**

| *DISEASES* | *Jan., 1945* | *Dec., 1944* | *Nov., 1944* | *Jan., 1944* | *Jan., 1943* |
|---|---|---|---|---|---|
| Chickenpox | 563 | 506 | 278 | 387 | 383 |
| Measles | 27 | 25 | 19 | 1085 | 738 |
| Scarlet Fever | 521 | 514 | 266 | 451 | 453 |
| Smallpox | 6 | 4 | 3 | 2 | 49 |
| Typhoid Fever | 4 | 1 | 6 | 47 | 6 |
| Whooping Cough | 54 | 42 | 44 | 81 | 109 |
| Diphtheria | 24 | 63 | 32 | 61 | 27 |
| Influenza | 28 | 37 | 19 | 573 | 78 |
| Pneumonia | 13 | 4 | 4 | 80 | 210 |
| Mumps | 220 | 89 | 56 | 120 | 291 |
| Poliomyelitis | 3 | 0 | 15 | 6 | 5 |
| Cerebrospinal Meningitis | 19 | 14 | 14 | 65 | 22 |
| Undulant Fever | 11 | 8 | 7 | 2 | 1 |
| Vincent's Angina | 1 | 1 | 0 | 1 | 25 |
| Tetanus | 1 | 0 | 0 | 0 | 0 |
| Tularemia | 6 | 27 | 1 | 5 | 10 |
| Encephalitis Lethargic | 1 | 0 | 1 | 0 | 0 |
| Rubella | 4 | 6 | 2 | 65 | 701 |
| Impetigo | 2 | 5 | 2 | 3 | 0 |
| Erysipelas | 1 | 1 | 0 | 0 | 0 |
| Trachoma | 2 | 0 | 1 | 1 | 1 |
| Malaria Outside U.S. (Acquired) | 1 | 0 | 0 | 0 | 0 |
| Malaria Inside U.S. (Acquired) | 2 | 0 | 1 | 37 | 0 |
| Tuberculosis, Pulmonary | 215 | 324 | 264 | 250 | 106 |
| Tuberculosis, Other Forms | 10 | 14 | 9 | 3 | 7 |


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# THE JOURNAL

OF THE

# INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

*ISSUED MONTHLY under Direction of the Council*

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 38 MAY, 1945 Number 5


## METHODS TO SAVE VISION


J. V. CASSADY, M.D.

CORLEY B. McFARLAND, M.D.

SOUTH BEND


This annual issue of THE JOURNAL, on the Conservation of Vision, is an endeavor to evaluate and correlate the "Methods to Improve Vision," "Methods to Save Vision," and "Methods to Prevent Blindness." These subjects overlap to some extent, yet they must all be a part of the program directed toward conservation of vision and prevention of blindness. Several years ago an attempt was made to arouse the cooperative effort of the various organizations along this line, but this failed because the different groups lacked a clear concept of the problem at hand. The organizations interested in aiding the blind took a dominant part in the program, but their interest in the end result was quite different from those interested in the prevention of blindness. We make a new plea for a state organization intended to conserve vision and prevent blindness, which will provide, through a lay organization, strong guidance and leadership. Such a group exists in Illinois and is doing a wonderful work for that state. Indiana needs such an organization.

Under the heading "Methods to Save Vision" much is included; however, time and space necessitate that certain limitations be made. Every physician should be acquainted with procedures now in usage and should be constantly on the alert for new and improved methods. The public is informed regarding most of the aspects of ocular care, and realizes that the responsibility for the care of eyes rests primarily with the individual. You, as a physician, should point out the importance of good eye hygiene and discourage such detrimental habits as reading on moving vehicles, reading in bed, the use of improper illumination and the incorrect positioning of reading material. You may find that one of these abuses will underlie the headache for which the patient consults you.

The importance of periodic eye examinations cannot be overemphasized. The early recognition of glaucoma or other intra-ocular pathology, diseases of the central nervous system or cardiovascular system is dependent upon the regular ophthalmologic examination. Often the patient who consults his doctor regarding an apparent disorder quite remote from the eye may be aided greatly by correction of a refractive error, re-establishing good ocular coordination and correcting faulty ocular habits.

Public education with respect to eye care should include the restriction of ocular usage during severe illness and convalescence. Many cases of strabismus may find their basis in the overuse of the eyes during an attack of measles or other infectious disease of childhood. A youngster should be isolated from school during a course of conjunctivitis, for infectious forms such as Koch-Weeks may be readily transmitted to others.

The public should be aware that such safety measures as the prohibition of slingshots, air rifles, fireworks and other such eye hazards are intended to save vision. Since the advent of anti-fireworks legislation in Indiana, the reduction of eye accidents has kept pace with the general incidence of fireworks accidents. Safety education in the public schools, industry and for the public in general has done much to save vision and to prevent blindness.

The student health council of colleges has helped to save vision by providing exhibits illustrating good study habits and disseminating information regarding eye hygiene and care. The motor vehicle law, which requires adequate visual acuity before a driver's license will be issued, does much to save vision, for it brings to the attention of a prospective driver the fact that he has diminished visual acuity and requires him to have this defect

corrected before a license will be issued. Education regarding good lighting in the home, in public places, and in schools is needed to provide an adequate visual economy.

The importance of early, proper, and adequate treatment of eye injuries cannot be overemphasized. A knowledge regarding the complete removal of a corneal foreign body along with the surrounding rust ring, the treatment of corneal abrasions, burns, lacerated wounds of the eye, lye burns and conjunctival foreign bodies should be a part of the general physician's armamentarium, or the patient should be referred to an ophthalmologist at the earliest possible time. Industry has cooperated by eliminating the various industrial hazards or providing safeguards on the dangerous machines which the employee uses. Improvement of lighting and the use of protective industrial goggles, with correcting lenses if necessary, has helped to eliminate the eye accidents which were commonly seen at the turn of the century. The physician who sees eye injuries should question the patient regarding such potential safeguards as may be necessary, and emphasize their use. During the present war effort and its associated industrial manpower shortage, visual requirements have been lowered, but as soon as normalcy is re-established these former standards should again be put into effect, so that the worker as well as the employer may benefit thereby. An individual who has good vision in one eye only does himself as well as his employer an injustice, for if the work involves any hazard the remaining eye may be injured and the individual be rendered totally blind.

In the future, job analysis based on visual efficiency will be a necessary part of industry's sight-saving program. Each prospective employee will thus be assigned to the proper job within the limitation of his visual capabilities. Such faculties as depth perception, field vision, and color vision will be measured. A job will be provided which is suited to the individual employee. Proper coordination of the extra-ocular muscles is necessary to prevent undue fatigue toward the end of the working day. General physical examinations carried out at periodic intervals, and good general health of the workers will do much to reduce the incidence of all accidents, and save vision. Entrance and periodic eye examinations of all workers, proper assignment to the correct job based on visual ability, correcting lenses, the use of properly-fitted industrial goggles and, where needed, the incorporation of correcting lenses in the goggle frame should be the concern of not only industrial physicians but of the entire medical profession. Respirators, goggles, and shields should be sterilizable to prevent cross infections. An adequate knowledge of eye infections is necessary so that contagious ocular disease, such as Neisserian conjunctivitis and epidemic keratoconjunctivitis, will not spread throughout the complement of an industry, thus bringing about the unnecessary loss of man-hours. A knowledge of first-aid treatment at the scene of the accident is necessary for such injuries as chemical eye burns or those caused by lime. The needless meddling with foreign bodies of the eye should be discouraged.

The greatest contribution in visual education is probably made by the school health program. Surveys of the eye records of college students show that the incidence of visual defects among college students is double as compared with a like group of industrial workers. There is a fear among college administrators and faculties, as well as among parents, that eye efficiency is a factor in the student's college success. However, a high percentage of honor students are myopic, and instead of its interfering with their intellectual progress it favors attention to study. An ophthalmologic examination and analysis of a student's eyes is just as necessary for four years of college as it is for an industrial plant. This examination should test not only the distant visual acuity, but also the near vision, muscle coordination, color vision, near point of convergence, and accommodation. Recommendations should be made for the correction of same if defects exist.

The periodic examination of school children has done much toward the recognition of early eye defects, and when corrected will conserve vision. The pre-school child is most amenable to eye correction, especially where muscle imbalance or amblyopia exists, and if the physician, on seeing such a child referred by the school nurse or visiting nurse, will cooperate in this program many eye defects may be corrected before they become permanent. It has been found that about 20 per cent of the children examined have some visual defect or subjective symptom of eye strain, or both. Approximately one child in seventy has crossed eyes. The early recognition of these defects is possible only through pre-school examinations and follow-up examinations each year thereafter. Such effort not only saves vision but eliminates the missed promotions and prolonged schooling of some children who are so handicapped that they can not progress normally. The sight-saving program in the school should include proper lighting of the school rooms and elimination of glare where possible, and proper arrangement and placement of windows and blackboards.

The ordinary child who may need correcting glasses will tolerate general school activities very well. Only about one in five hundred of the school population will need special educational procedures. Children who have less than 20/70 (Snellen) visual acuity in the better eye have difficulty in attending to the requirements of a general school course, and should be put in a sight-saving class. Such classes are provided in all the larger cities, and provision is made for children from smaller towns to attend where these facilities are not available. Thus, the public school system will accommodate those children with a visual acuity of 20/70 to 20/200 (Snellen), where formerly some of these young-

sters were required to seek a school for the blind. This association makes for a more normal emotional content, and a better understanding is obtained by the child, both with reference to his school work and his ability to get along with his fellow students. The sight-saving class also provides a place where supervision of the course of the amblyopia may be had, and the physician may know that his young patient is receiving the correct amount of visual stimulation.

These and many other methods are now provided to conserve vision. The cooperation of the medical profession with educational programs, with industry, and in all phases of visual conservation is necessary to adequately save vision and prevent blindness.

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# METHODS TO IMPROVE VISION

EUGENE L. BULSON, M.D.

FORT WAYNE

When the average individual with impaired or subnormal vision, or one who has been suffering from headache, blurred vision, and ocular fatigue after moderate use of the eyes, or from the many other symptoms which may be caused by eyestrain, decides that it is high time to do something about it, the first thought that naturally occurs to him is that he either needs glasses or that he needs a change in the ones he is wearing, so he consults an ophthalmologist or, more often, an optometrist to have his eyes tested. The average person does not realize, unless he has learned from past experience, that there is a great deal more to a competent, thorough examination of the eyes than the mere determination of the refractive error and the subsequent fitting of corrective lenses. The conscientious optometrist, and fortunately there are many, who fails to improve the patient's vision to any marked degree, or feels that there may be some cause other than a refractive error to account for the symptoms, will advise the patient to consult an eye physician for a more thorough examination.

Obviously, persons whose vision is impaired as a result of high degrees of hyperopia, myopia, or astigmatism require corrective lenses to improve their visual acuity, and the greater the amount of the refractive error, the greater becomes the necessity for correction. The determination of the amount of the refractive error is best done by the ophthalmologist, with the patient's accommodation completely relaxed under cycloplegia. Only under these conditions can an accurate estimation of the refractive error be determined; this is of greatest importance in children of pre-school age and in young adults, and it is the practice of many ophthalmologists to employ a cycloplegic in persons up to forty-five years of age, wherever it seems to be indicated. Certainly the arguments for the use of a cycloplegic, in competent hands, more than outweigh those against its use.

Hyperopia in children under five years of age is one of the commonest causes of convergent squint. This may be only temporary at first, but as soon as it is noticed the child should be examined by an eye physician, for the earlier the condition is corrected, the better the chances are for preventing it, or for curing it entirely by means of appropriate lenses. The old adage so frequently given the parents of these unfortunate little tots, that "they will outgrow it," is all nonsense and without any factual basis. Children with very high degrees of hyperopia may actually seem "near-sighted" or myopic because they have the tendency to bury their heads in a book, and anything which they wish to look at intently they bring very close to their eyes. The reason for this is that they lack the accommodation necessary to see objects distinctly at a close point, and the closer they bring objects to their eyes, the larger the retinal image becomes. These children are prone to develop conjunctivitis and blepharitis; nervousness, anorexia, and inability to concentrate on any given task for any length of time are other symptoms frequently encountered.

At first the squint may be of only temporary duration, manifesting itself when the child is physically tired or after prolonged use of the eyes. However, unless the squint is corrected at an early age by corrective glasses, it will continue to develop until the child is no longer able to hold the squinting eye in focus with its fellow eye, and it then becomes definitely crossed. As a result of this, anomalous retinal correspondence occurs with attendant diplopia, during which time the child may stumble over objects until he learns to suppress the image in the squinting eye. From this time on the squinting eye becomes amblyopic as a result of suppression of the retinal image, and if the condition is allowed to persist without adequate medical eye care the weaker eye will remain defective both in visual acuity and the ability to function normally with the fellow eye. The longer the condition is allowed to go without attention, the more difficult it becomes to correct it with glasses alone, so that it often becomes necessary to re-educate the squinting eye, both in its ability to see and function in coordination with the other eye, by occlusion of the stronger eye and by means of orthoptic training, which in many instances

can be accomplished by assiduous work on the part of the child unless the condition has existed for too long a time, or other complicating factors are present which might prevent any beneficial results from such procedures. Most gratifying results have been obtained from orthoptic training, not only in improving or restoring the vision in an amblyopic eye, but in educating it to function normally with the fellow eye.

According to statistics most eyes are hyperopic at birth; myopia, or near-sightedness, develops later, so that between the ages of five and ten years approximately 8 per cent of the eyes among children are myopic, and this increases so that at twenty years of age the percentage has reached 25.7 per cent, according to Jackson. The cause of early myopia is attributed to the continued growth of the eye in its anteroposterior diameter beyond the time at which it should stop, chiefly as a result of excessive use of the eyes for near work, improper lighting conditions, and imperfect vision from any cause. Eyes that have been damaged from childhood, either as a result of disease or trauma, are inclined to develop myopia. Obviously, these individuals whose vision is exceptional at a close point need corrective lenses in order to see clearly at a distance, yet it is surprising how many of them with fairly large errors of refraction get along without glasses. To be sure, the vision of these individuals is anything but fair, yet it seems to be sufficient to satisfy their visual requirements, probably because they have never learned to see any better.

In certain abnormal conditions of the eye, lenses of a highly-specialized type are required in order to improve the vision materially, for example, keratoconus, or conical cornea, in which the cornea of the eye is pushed forward by the intra-ocular pressure, as a result of a weakening of the corneal tissue produced by a disturbance of the corneal nutrition caused by an acute or chronic illness. In these cases contact glasses are very beneficial in improving the vision. The contact glass is moulded from glass, and more recently from a transparent plastic with low refractive index, to conform to the anterior curvature of the cornea. The glass does not rest directly on the surface of the cornea, but is separated by a film of physiologic sodium chloride or other suitable solution which must be determined by experiment with the patient. Other conditions in which contact lenses are a distinct benefit are in cases of excessive degrees of myopia. The length of time a contact lens may be worn by an individual depends upon the emotional and nervous stability of the patient, and upon the individual tolerance. Some persons can wear a contact glass eight or ten hours without discomfort; others may be able to wear one for an hour or two only; while others can not accustom themselves to wear one at all. Needless to say, the fitting of a contact lense is a highly technical procedure, and one which should under no circumstances be undertaken by one not skilled in the technique. The question is often asked whether contact lenses can not be used instead of ordinary glasses or spectacles for general wear, because of the inconspicuousness of the lenses when they are worn, and the answer, at least at present writing, is "No." Contact lenses are sometimes worn by stage and screen actors, who have high degrees of myopia, for short periods of time when they do not wish to appear before the public wearing glasses, or at times when the wearing of glasses may be inconvenient or detrimental to their appearance.

The use of telescopic spectacles as a means of improving vision is limited in the extreme. While the vision in many conditions might be improved by their use, most persons object to them because of their conspicuousness, size, and weight. In addition to this, their cost and difficulty of adjustment make them more objectionable.

Another condition of the eyes which requires the use of corrective lenses, which is not infrequently encountered and which is seldom recognized, is that known as "aniseikonia," in which the size and/or shape of the retinal image of one eye differs from that of the other. The individual with this abnormal eye condition may exhibit symptoms not unlike those associated with the commoner errors of refraction, but the difference in size of the retinal images disturbs the binocular (stereoscopic) spatial localization, so that objects equally distant from the observer may appear to be at different relative distances from one another, and their shape and size may appear to be altered. Frequently the so-called "migraine headache" is produced by the disparity in the size of ocular images to which the eyes can not adjust themselves. The presence of this condition can only be determined and measured by means of a specially-designed instrument known as the ophthalmoeikonometer. From the tests made by the use of this instrument iseikonic lenses are designed to correct the disparity in the size and shape of the images formed on the retinae of the two eyes.

When all is said and done, the question of practical importance resolves in this: Does the individual need glasses, and, if so, what type will best suit his needs for the particular task to be accomplished? In order to determine this point, a great many factors have to be considered, and the solution of the problem taxes not only the skill of the ophthalmologist but his ingenuity and experience as well. Each patient with ocular difficulty presents an individual problem, and the question of whether or not the amount of the refractive error is sufficient to impair the usefulness of the eye, or the comfort and health of the user, is not in all cases easily answered. The final analysis depends not only upon the amount of the refractive error, but also upon the use to which the eyes are to be put, and the ability of the individual to endure sustained effort and strain in the use of the eyes for the specified task without impairment to the ocular structures and to the patient's well-being.

A relatively small error of refraction may be borne, without producing any symptoms at all, by the average person who has never used his eyes for a more severe task than reading the newspapers or reading an occasional magazine article. The same individual, as soon as he starts using his eyes for tasks at a close point, to which they are unaccustomed, immediately begins to have headaches, blurred vision after constant use of the eyes, inability to focus when the eyes are diverted from close work to distance seeing, et cetera. This fact has been emphasized very strongly during the present emergency when those accustomed to an outdoor existence, such as farmers and others, suddenly have been transferred to some indoor work which requires constant close application of the eyes to the task to be accomplished, such as desk work, lathe and machine work requiring the reading of minute scales, and the machining of precision instruments to 1/1000 of an inch or less, which requires not only the utmost in seeing ability but in accommodation as well. Many of these workers who have never needed glasses before, because of their occupational necessities, need them at the present time because of the increased number of hours they are using their eyes, and because of the tasks which they are called upon to perform.

Many laymen consult the ophthalmologist in the belief that they need "new glasses," without realizing that many other factors may be responsible for their impaired vision. Any diminution in the transparency or the light-transmitting power of any of the refractive media of the eye can materially affect its usefulness and the ability to see clearly. Opacities or scars in the cornea of an eye may seriously handicap an individual from that of merely blurred vision to total blindness, depending on the location and density of the scars which may have been caused by deeply-imbedded foreign bodies, ulcerations, trauma, or disease. Likewise, opacities in the crystalline lens, or cataracts, are frequently the cause of impaired vision, particularly in elderly individuals. Exudates or hemorrhage into the vitreous, as well as similar conditions in the retina and choroid, from whatever cause, may seriously interfere with the person's ability to see clearly. Other conditions which may affect the delicate structures on the inside of the eye, producing impaired vision or blindness, are the various diseases which affect the retina and the optic nerve. These will doubtless be discussed in other articles appearing in this issue. The subject of glaucoma, which in our opinion is one of the most devastating diseases to which the human eye is subject, because of its insidious nature and for this reason is so frequently unrecognized, is a subject in itself and will not be discussed in this article. Suffice it to say that the incidence of this disease among those of middle life or beyond is far greater than most general physicians realize, with the result that many individuals with this disease become blind whose vision might otherwise have been spared had the disease been recognized in its incipiency and appropriate measures adopted to check its advance.

In regard to corneal opacities and scars, many beneficial results have been obtained by keratectomy and keratoplasty, the latter procedure involving the transplantation of a segment of healthy, transparent cornea to that of the diseased or traumatized eye, according to the technique, so successfully used and advocated by Ramon Castroviejo, M.D., of New York City, and others in this specialized branch of ophthalmic surgery. Many cases of corneal opacities have been reported in which there was partial or almost complete loss of vision and in which useful vision was restored by means of these surgical procedures.

The question of whether or not a person's vision can be improved depends not only upon a determination of the amount of the refractive error, and whether or not his vision can be improved by corrective lenses alone, but also upon what other measures might be adopted to improve the vision, or what treatment might be instituted to correct the pathological condition responsible for the impairment. In order to obtain this ideal, in the interest of the patient, the ophthalmologist and the general physician, a close spirit of harmony and cooperation should exist.

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## ABSTRACT: PENICILLIN ADMINISTERED BY MOUTH

British observers, according to The Journal of the American Medical Association for April 14, have found the administration of penicillin by mouth with sodium bicarbonate and egg to be satisfactory in cases of tonsilitis. In an editorial The Journal states that the method is now on trial in the treatment of gonorrhea, pneumonia and surgical sepsis.

Because penicillin is sensitive to acid and alkaline reaction and is easily destroyed by the gastric juices of the stomach, its effective administration by mouth has presented difficulties. Its rate and degree of absorption in the body can be measured by the absorption of penicillin in the blood and the amount of penicillin excreted through the kidneys into the urine.

The Journal says that simplified methods of administering penicillin that will provide adequate and prolonged blood concentrations are being sought by many investigators. Crystalline penicillin has been combined with human plasma proteins for muscular injection. Penicillin has been given by mouth with trisodium citrate which eliminates the destructive action on penicillin by the hydrochloric acid in the stomach.

Now, The Journal says, "in a volunteer with gastric hyperacidity the most satisfactory excretion of penicillin in the urine occurred when he was given alkali, sodium bicarbonate, followed by penicillin mixed with raw egg. Three other volunteers received this mixture with successful results. The same dose of alkali and egg penicillin was given to a patient with achlorhydria to test the possibility of destroying the action of penicillin by over-alkalization. In this patient also the urinary excretion of penicillin was normal. Early tests on volunteers and patients showed that when 20,000 units of penicillin was taken orally the proportion excreted in the urine was 75 to 80 per cent, which is much the same as for the intramuscular administration of 15,000 units. . . ."

# METHODS TO PREVENT BLINDNESS

ORRIS T. ALLEN, M.D.

TERRE HAUTE

Methods to prevent blindness are becoming of increasing importance. Each passing year the things we hope to do, as physicians, are to awaken, if possible, an active public interest in the question of the prevention of blindness.

The child is born with possibly only motion sense. Within the first few weeks it learns to fix its eyes on objects. From that time on there is gradual improvement in the acuity of vision until about puberty. These facts should be kept in mind by the general practitioner.

About the first test of vision in the babe is to note whether or not it will follow a moving object with the eyes. That is a sufficient test for a child three to six weeks old. A little later, say three to six months of age, it is well to note if the child's eyes coordinate in their movements. This is best accomplished by holding a lighted candle in front of the child's eyes, and noting whether the reflection of the candle flame is in the center of each pupil. It is very easy in this way to detect a converging or diverging eye. It is well to remember that if the eyes do not focus together, only one eye will be used, and only that eye will properly develop vision. The amount of convergence or divergence is also a very important factor. If the reflection of the candle flame falls in the center of the right eye, and on the outer margin of the pupil in the left eye, it means that the child has about 15 degrees convergence of the left eye. This child, if fitted with glasses at four or five years of age, will usually develop perfectly good vision in both eyes. If the candle test shows the flame reflection half way between the margin of the pupil and the limbus on the converging eye, it means about thirty degrees of convergence. This case should be referred to an oculist by the time the child is three years old. If the candle test shows the reflection of the flame on the limbus, or near the limbus of the converging eye, the child should be referred to an oculist by the time he is two years old. The reason for this is that the farther the eye converges, the less vision the child will have at puberty. If the condition is not corrected the child with fifteen degrees convergence, if uncorrected, will have about 20/100 vision at maturity. The child with thirty degrees convergence, if uncorrected until puberty, will have about 20/200 vision. The child with forty-five degrees convergence, if uncorrected until maturity, will have 20/300, or less, vision in the converging eye. The same can be said for diverging eyes, although they are much less frequently observed and require different treatment.

The obstetrician should never fail to observe the rule of instilling 1 per cent silver nitrate in the eyes of every newborn babe. This should be done as early as possible. This may be followed by irrigation of the eyes with normal salt solution. In case the eyes later show some infection an oculist should be consulted immediately. If this is not possible the eyes should be made as free of pus as possible by frequent irrigation with normal salt solution or some mild antiseptic. The most important factor is never to permit any object to touch the cornea. Corneal ulcer will not develop in these eyes if they are frequently cleaned by irrigation and the cornea is not traumatized. The gonococcus will not attack a healthy cornea. If ulcer forms the eye will always be lost. This is where a stitch in time saves a patch in eternity.

### GLAUCOMA

Glaucoma is one of the most common causes of blindness. It occurs in children occasionally and is called buphthalmos. In adults the scleral coat of the eye is very firm and does not stretch when under pressure, but in children the tissues are not so firm and the eyeball with tension will become enlarged. It is well to remember that the child with exceptionally large eyes may have buphthalmos. Children are not apt to have pain with this condition.

In older individuals there are two types of glaucoma, the acute and the chronic. The acute comes on suddenly and is very painful. It is often mistaken by the general physician for sinus trouble or ordinary headache. The eye is usually markedly congested. One can usually detect it by palpating the eyes with the forefinger of each hand, thereby comparing the tension of the two eyes. The pupil will often be dilated in the eye with acute tension. There is also a difference of sensitivity in the normal eye and the one with the tension. This can often be detected by drawing a small wisp of cotton across the eyes and noting the degree of sensitivity in the two eyes. The patient with either acute or chronic glaucoma will often complain of seeing a halo of colors about a light. This is due to edema of the cornea and is always suggestive of glaucoma. By comparison of the corneas one will often note a cloudy condition of the cornea with acute tension. These cases should be referred to the oculist at once, as a high tension for twenty-four to forty-eight hours will usually cause eventual loss of the eye even if successfully operated. Vigorous and frequently-repeated massage is often very successful in keeping the tension down until the patient is able to reach the oculist.

Chronic glaucoma is more insidious in onset and less easily detected, and is therefore responsible for many more cases of loss of vision. It occurs much more frequently in the female, and is more common after the third decade. The exciting cause is often some emotional disturbance. The loss of

a near relative or friend is frequently followed by an attack of glaucoma in eyes that are predisposed. This is probably due to dilation of the pupil, which occurs with emotional disturbance. Morning headache, tired eyes, and the necessity for frequent change of glasses in presbyopia are all very suggestive of the possibility of glaucoma. One will often note a lack of normal sensitivity of the cornea in these cases by drawing a small pointed wisp of cotton across the cornea. Unequal pupils, the larger on the affected side, may suggest chronic glaucoma. When glaucoma is suspected the case should be promptly referred to an oculist without, however, unduly exciting the patient.

It is my opinion that those who have learned to use their eyes properly for close work are not so apt to develop tension as the fussy individual who claims that he can never do close work with comfort. In the act of accommodation the ciliary muscle pulls on the scleral spur and thereby opens the canal of Schlemm, thus facilitating drainage of the fluid from the eye. I therefore tell patients with tension or suspected tension to read or do all the close work they want to do. I think it is beneficial. I certainly have never seen any harm from this practice. Massage is always indicated in these cases, and the patients can readily be taught to do it themselves. It is my opinion that the individual who has learned early in life to use his eyes properly for close work, and continues to do so, is not so apt to develop glaucoma and cataract as those who have not learned to do so. It is well to remember that normal, healthy exercise of the eye is just as beneficial as it is for any other part of the body. This increases circulation, facilitates drainage through Schlemm's canal and thereby prevents early senile changes in the eye. Too many people are afraid of eye strain.

### FOREIGN BODIES IN THE EYE

Foreign bodies in the eye demand immediate treatment. If they are on the upper lid they cause more immediate distress than if located on the cornea.

The patient with a foreign body on the upper lid usually demands immediate attention. These can be easily removed by everting the lid and removing the foreign body with a pledget of wet cotton on a toothpick. The presbyopic doctor may not be able to see it, but by doing it this way he can readily remove it. After the presbyopic age it is never safe to say that there is no foreign body on the lid or cornea unless one has a good binocular loop and proper glasses to aid in seeing very small foreign bodies.

The foreign body on the upper lid will soon develop congestion and photophobia, while if located on the cornea it may not do so. It is not an infrequent experience to see a patient who has had a foreign body on the cornea for a week. It usually bothers him more at night when he can not get a doctor. Then through the day it is better, and he decides the foreign body has been washed out by the tears.

No anesthesia is required to remove a foreign body from the upper lid, but is necessary if it is on the cornea, except that in some cases it can be wiped off the unanesthetized cornea with wet cotton rolled on a toothpick. This should never be attempted with dry cotton for that will abrade the cornea and increase the discomfort of the patient even if one succeeds in removing the foreign body. If the foreign body is stuck tight to or buried in the cornea the case should be referred to an oculist.

Ordinary tap water will help to lessen the distress which results from a foreign body, for by causing an edema of the cornea it thereby interferes with sensation to a certain extent. Butyn, pontocaine or cocaine may be used temporarily if the patient cannot get to an oculist, but it is well to remember that these drugs may cause the patient to neglect proper care of the eye, and may lead to serious infection of the cornea and loss of vision. A foreign body near the limbus, that is the outer rim of the cornea, does not cause so much distress as one in the region of the pupil, also one buried deeply in the cornea does not cause as much distress as one located superficially. Hence, the deep one which does not cause so much distress may be neglected longer, and may thereby become infected.

### TRACHOMA

The spread of trachoma is being rapidly checked all over the world. We have certainly accomplished much in Indiana. Most of the cases are in the southern part of Indiana. The fight will, however, have to be kept up for many years in order to eradicate it completely.

Suggestive indications are repeated attacks of acute conjunctivitis, which cannot be otherwise explained. It is well to look into the history of contacts in these cases. A Walker lid hook that will really evert the lid and expose the conjunctiva of the upper cul-de-sac is a valuable aid in diagnosis. Frequently one will find a thickened conjunctiva in the upper part of the cul-de-sac with a quilted appearance. This is one of the earliest signs.

Nutrition is undoubtedly a factor, as shown by the late Dr. Stucky of Kentucky. Hence, good nourishment is an aid in treatment.

The sulfa drugs are very valuable in its treatment. In cases of secondary ulceration and pannus, atropine must be used. Drooping lids are a later sign and often aids in the diagnosis in unilateral cases. These cases are rare in the colored race, although I have seen and treated three undoubted cases. This disease can be eradicated if the general practitioner is on the alert. These cases should all be reported to the State Board of Health. They are only mildly contagious, but are much more so during acute exacerbations.

### ACUTE INFECTIOUS DISEASES

In many acute infectious diseases, where the patient is seriously ill, an acute infection of the

eyes is often neglected as of minor importance. Many eyes are lost in this way.

At the first appearance of an infection of the eyes they should be carefully inspected, and if there are no signs of corneal irritation the conjunctivitis should be treated by frequent irrigation with a mild antiseptic solution, always being careful not to injure the cornea. If pus is permitted to remain in the eye too long it is liable to devitalize the corneal epithelium and lead to corneal ulcer.

If there is any question of corneal involvement, a drop of fluorescein 2 per cent solution should be instilled on the cornea, then carefully washed out. It will stain abraded corneal areas a greenish-yellow. If these stained areas are found, atropine should be used at once and an oculist consulted.

#### DIABETES AND HYPERTENSION

Visual tests should be taken in these cases by the general practitioner, and in case of loss of vision the patient should be referred to an oculist. A careful examination of the fundus is always best in these cases.

#### SYPHILITIC CASES

Here we have interstitial keratitis which as a rule requires careful observation and treatment over a long period. This is rarely found in adults. Specific constitutional treatment is of little benefit in these cases. The treatment of these cases should be handled by the oculist, or at least supervised by him. Marked photophobia and cloudy cornea are the most important signs. Four per cent atropine ointment should be used early and the pupil should be kept dilated.

A beautiful red tumor growth on the iris is practically always a syphilitic gumma and will respond readily to antisyphilitic treatment. Fundus examination by the oculist is important in these cases. (First-aid treatment should consist in carefully cleansing with normal salt solution and closing the eye with a clean sterile patch.) Careful periodic visual tests in schools and in industry should do much to save eyes and lessen the load on the taxpayers. What greater incentive is needed?

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# VISUAL REQUIREMENTS FOR THE ARMED SERVICES*

VICTOR A. TEIXLER, M.D.

INDIANAPOLIS

The visual requirements for the armed forces have been changed only slightly since the beginning of Selective Service. There have been minor changes in the visual standards, and some ocular conditions which were first considered acceptable have since been placed in the limited service or nonacceptable group. We will first present the requirements of the United States Army as set out in the mobilization regulations.[1]

#### UNITED STATES ARMY

The visual acuity is determined by standard methods, each eye being examined separately, with and without glasses. The army uses the Snellen test type with the English fraction in feet as the measurement.

The selectees are graded in three groups: general service, limited service, and nonacceptable group. The requirements for general service are that the registrant have a visual acuity, without glasses, of not less than 20/200 in each eye. This must be correctable to 20/40 in each eye, and the defective vision must not be due to any active or progressive organic disease. The actual possession of suitable glasses by the individual is not required for his acceptance in general service.

The following ocular conditions are considered acceptable in general service:

1. Small pterygium not encroaching on cornea so as to interfere with vision.
2. Ptosis which does not interfere with vision.
3. Color blindness.
4. Exophthalmos, if not of such a degree as to have led to corneal ulceration and provided hyperthyroidism, is excluded.
5. Blepharitis marginalis, if mild.
6. Superficial corneal ulcer, provided acceptance is deferred until ulcer is healed without disqualifying impairment of vision.
7. Conditions due to iridectomy or any other surgical operation of the eye, if the condition for which the operation was performed has been removed and the vision is within or about the minimum standard requirements.
8. Nystagmoid movements are considered acceptable if they are not persistent or pronounced and a true nystagmus can be excluded.

The standards for limited service are a minimum vision of 20/400 in each eye without glasses, correctable to 20/40 in each eye. The loss of one eye or any degree of defective vision in one eye, from below 20/400 to no light perception, if such defective vision is not due to active or progressive organic disease, with vision in the other eye of 20/100 without glasses correctable to 20/20 with glasses. Selectees with such vision as just mentioned are acceptable for limited service with the

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* Approved by the Fifth Army Service Command.

[1] United States Army Mobilization regulations MR-19.

ocular conditions listed under general service. At present limited servicemen are not being accepted since there is only a need for men fit for combat duty.

The following defects are considered nonacceptable:

1. Vision less than the minimum requirements for limited military service.
2. Deformity of eyelid or eyelids, such as inversion or eversion of a degree that forceable closure fails to cover the eyeball, or of which there is a resultant conjunctival inflammation, corneal irritation, or a restriction of the rotation of the eyeball.
3. Lagophthalmos, if extreme.
4. Pronounced exophthalmos.
5. Chronic keratitis.
6. Chronic recurrent inflammatory disease of the corneal or uveal tract.
7. Chronic ulcer of the cornea.
8. Any active disease of the retina, choroid, or optic nerve.
9. Detachment of the retina.
10. Nystagmus.
11. Glaucoma.
12. Diplopia due to paralysis of extrinsic ocular muscles, unless mild in degree.
13. Abnormal conditions of the eye due to diseases of the brain.
14. Trachoma.
15. Any tumor of the orbit.
16. Permanent and well-marked strabismus (over thirty degrees deviation).
17. Ptosis interfering with vision.
18. Trichiasis.
19. Chronic conjunctivitis.
20. Chronic dacryocystitis.
21. Pterygium interfering with vision.
22. Adhesions of lid to the eyeball.
23. Blepharospasm.

Commissioned officers in the Army are required to have a vision of 20/40 in each eye correctable to 20/20 in one eye and 20/30 in the other. Glasses are not necessary.

### THE UNITED STATES NAVY AND THE UNITED STATES MARINE CORPS**

The United States Navy and the United States Marine Corps use a slightly different method of measuring and recording the visual acuity. The test letters are all of the same size and are equivalent to the 20/20 line of the Snellen test type. Starting at the twenty-foot line, the inductee walks forward until he is able to read the 20/20 line. In this fraction the numerator denotes the distance the selectee is from the chart when he is able to read the type. Thus, if he is ten feet from the chart his vision is 10/20.

The minimum visual requirements for inductees in the United States Navy and Marine Corps is 6/20 in one eye and 10/20 in the other, or 10/20 binocular vision. In respect to ocular defects, they are somewhat the same as that of the general service in the Army, except that color blindness is not acceptable. There is no limited service in the Navy, but some men are acceptable under special asignment where the visual requirements are slightly less than that of general service in the Navy, but not as low as limited service in the Army. The visual requirements for special assignments is 2/20, if correctable to 10/20 in each eye. Selectees who are color blind are acceptable for special assignment in the Navy.

The same conditions as are listed under nonacceptable in the Army also pertain to the Navy and the Marine Corps, except for the following: these branches of the service will not accept ptosis, any pterygium on the cornea, coloboma of the uveal tract, strabismus, or asthenopia with ocular defects.

The Navy line officer must have a vision of 18/20 in each eye correctable to 20/20 in each eye. Commissioned officers such as Medical Corps, Supply Corps, Dental Corps, civil engineers, chaplains, and legal specialists are required to have 12/20 in each eye correctable to 20/20 in each eye.

### AIR CORPS—ARMY AND NAVY

Air Corps ophthalmic requirements in the Army and Navy, which included the Marine Corps and Coast Guards, are basically similar.

Functional requirements are:

1. Visual acuity of 20/20 in each eye without glasses.
2. Less than fifteen degrees of contraction in any meridian of the visual field.
3. Depth perception of 30 millimeter limit at six meters with the Howard-Dolman apparatus.
4. No heterotropia or esophoria of less than 10 D, exophoria less than 5 D, and hyperphoria less an 1 D.
5. There must be no diplopia within fifty centimeters in any meridian.
6. Power of divergence must be less than 15 and more than 3 D.
7. Accommodation must be less than 3 D below normal age.[2]

### MISCELLANEOUS

Color vision in the Army is tested with the Ishihara test, Stilling's plates and Holmgren skeins. The Navy uses Stilling's plates along with the Edridge-green lamp as supplementary test.

While examining inductees at the Indianapolis Induction Station I found that around 1 per cent of the men examined were malingerers. Some of these men exaggerated their visual defects while others were out-and-out malingerers. We used colored lenses and prisms to detect malingering.

** Communication with Lieutenant Commander Byron Rust, United States Navy.

[2] Bahn, C. A.: Requirements of the Military Services, *Arch. of Opth.*, 27:1202 (June) 1942.

224 Hume Mansur Building
Indianapolis 4, Indiana

*THE JOURNAL*
OF THE
INDIANA STATE MEDICAL ASSOCIATION
DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA
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MAY, 1945

# Editorials

## CONSERVATION OF VISION

For several years THE JOURNAL has devoted its May issue to the subject "Conservation of Vision." We know of no matter of greater importance than this subject, and feel that our efforts in that direction, through the years, has borne fruit. The present number upholds the record we have made in the past; the field is pretty well covered, the articles having been prepared by those proficient in the subject, and all of them are timely.

We have many readers of this special number, other than medical folk; in the large industries we find safety departments vitally interested in what we have to say on the subject. And a number of employes, especially in the steel industry, have evinced a more than common interest in the subject.

Conservation of Vision is a huge field. It deals not only with accident prevention, involving the eyes; it covers the various diseases that will result in damage to vision if not properly treated. It also includes a consideration of efficient lighting in the shop, in the school, and in the home. Inadequate and improper lighting affects the eyes of growing children, as well as adults.

Eye physicians are concerned not only with the treatment but with prevention of disease, as well as prevention of accidents, which is a most important factor. There is too much incompetency in these fields; too much improper, unfounded advice is given as to the eye and its care. We listen to "tall stories" along these lines almost every day. Some optometrists evidently feel called upon to deliver a homily to almost every patient, and some of their comments are most interesting.

Then, too, we have too many physicians who dabble with eye cases—physicians who are not especially trained in this work but who continue to take on such cases as come along. This is especially true of refraction. We have in mind one chap who essays refractions, be it either with the young or the old. As was stated by a confrere, this man is "Hell on Myopia." In reviewing his work we find that most of his patients are given a correction for myopia.

It is our observation, however, that refraction and eye care in general is on the up-grade. Much of this is due to the fact that the lay public is fast becoming eye-conscious. Much of this is also brought about by our present examination requirements connected with employment in most of our industries. The employer knows the value of good vision in his employees, and demands proper correction.

The JOURNAL takes this occasion to thank the eye physicians who have made this number possible. For the past several years we have turned the entire program over to the members of our Conservation of Vision Committee, who at times also call in officers of the Indiana Academy of Ophthalmology and Otolaryngology, and who together plan the entire number. This year Dr. J. V. Cassady, of South Bend, is the chairman of this committee, and we are, indeed, grateful to him for engineering this issue.

Again we say, we believe that this is one of the most important issues published, and we are glad to contribute space to such an important program.

## "TOMMY" HENDRICKS

So that's his name! It must be, for we took it right out of his home-town paper, the *Indianapolis News*. In our many trips to the capital city we rather often have heard him addressed as "Tommy," by Indianapolis folk, but never have felt free to be so familiar with one who is our boss. For a long time Tommy has guided the destinies of the Indiana State Medical Association, and has done a good job of it. Intermittently, he has messed around a bit in Hoosier politics and has served as Marion County representative, later serving for eight years as senator from his home county.

Now he has a new distinction, having been officially recognized by the august American Medical Association, which body recently named him as sec-

retary of its Council on Medical Service and Public Relations. We, of course, have known about this for a long time, but have been hesitant to publish the information. Now that the local papers and the *Bulletin* of the Indianapolis Medical Society have broadcast the news, we feel free to talk about it.

Tom is doing part-time work for the A.M.A., under a sort of Lend-Lease agreement. In fact, one-half of his time is spent in Chicago, the other half at the headquarters at Indianapolis. So, we have a half-secretary in Indianapolis these days. But even with just half we are faring very well, since the Blonde Boss is so full of the old "P and V" that he is fully able to care for both jobs.

As the *Indianapolis News* expresses it, Tom is leading "the life of Riley" these days, since he commutes to Chicago, using the James Whitcomb Riley, New York Central special train, for his trips.

Indiana Medicine is very proud of the fact that one of its officers should have been invited to take over the responsible position of secretary to this Council, at once one of the most important groups in the family of the American Medical Association. As a matter of fact, this work is of the pioneering sort, since it is really a new venture on the part of the parent body.

For a good many years there has been a demand from many parts of the country for something like this, but the pleas seemed to have fallen on deaf ears. We recall that as far back as 1932 there was such a demand made in a meeting of the Secretaries-Editors.

And, we make bold to state, that already there has been a definite "pep up" in the pronouncements of this Council; no longer are the bulletins so thoroughly dignified as to carry little weight. They are live, understandable, informative statements, coming from an old newspaper man who retains his ability to write in an entertaining manner, yet "carry a message to Garcia" in a convincing manner.

We will get along down here in Indiana with our spark plug hitting on but two cylinders; we have the organization needed for carrying on our work, and that work will go on and on, just like it has for many years past. Somehow or other, Hoosier Medicine either knows all the answers or finds them in a jiffy. We do not recall one instance in which we have not met an emergency.

So, let's plug along, just as we have in the past, knowing that "Tommy" Hendricks still is batting fourth position in our line-up, and at the same time doing a swell job at 535 North Dearborn Street, Chicago.

## THE DOCTOR'S TELEPHONE

This is rather an odd subject for an editorial in a medical magazine, but one which we have been threatening to comment on for many moons. The scene is that of a busy doctor's office—war-busy, if you please. He pauses to answer the telephone, and is told: "This is Doctor 'Big Shot's office' calling; he wishes to speak to you; please hold the wire." Well, we hold on like grim death until "Big Shot" finishes an examination of a patient, or perhaps relates how he made a-hole-in-one last week on a golf course. Finally, he deigns to talk, and says, "Can you give me the name of a good pediatrician in Timbuktu? I have a family moving down there, and they want to consult a good man in that field." Well, we look it up and give the best information at hand, answering several other inquiries as to the age of the specialist, his school and year of graduation, office hours, et cetera.

Now, while we are glad to be able to be of service, all this takes time, and if the call had been made directly by the doctor himself much time could have been saved. The trouble is that the call-*er* does not realize that the call-*ee* is probably as busy as he is!

A long time ago, when all doctors did not have secretaries, we could spot a new gal in a medical office right off, for no sooner had she been installed until the doctor would say, "Get Dr. —— on the wire." The said Dr. —— would have to stay on the telephone for a sufficient length of time to become impressed with the fact that he was being called by a busy man. Yet some of the busiest doctors we know can be reached directly by phone, without the caller having to give his name and state his business; this also applies to busy men outside the medical field.

We once knew a doctor, a busy man, who answered *no* phone calls during office hours. We had occasion to call him several times, each time being advised that although he was in he could not be reached by phone at that particular time. Once his office hours were completed, this doctor took the phone calls in order and made each one of them himself. Quite some system, we thought.

We would urge that a little more consideration be given the doctor to whom you wish to talk by phone; why not call him directly? As we have said, his time, too, probably is important. (We feel much better, having gotten this off our chest!)

## Editorial Notes

London authorities state that penicillin has a new rival, hypholin, a sort of "chemical cousin," since both come from the same mold. They also state that there are at least twenty "close relatives" of penicillin, and that each of these will come in for a thorough investigation as to their probable therapeutic value.

Senator Wagner, of New York, co-author of the Wagner-Murray-Dingell Bill, has a new bill under preparation, details of which have not yet been announced. However, he terms it the "happiness prosperity program," and states that it will provide bigger expenditures for national health.

Transplantation of a cornea, by a grafting operation, is not a new experiment, it having been tried over a long period of years with an increasing degree of success. Now there has been established an "Eye Bank," duly incorporated under the laws of the State of New York, with headquarters at 210 East 64th Street, New York City. It is the plan of the "Bank" to have both fresh and preserved corneal tissue on hand at all times.

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We learn from the *Elkhart Truth* that since the organization of the Elkhart General Hospital there has never been a medical member on the Board of Trustees of that institution, and that steps now are being taken to change the constitution and by-laws so that physicians may be represented on the board. While we have known of some private hospitals that had an all-lay board, the news that a county institution was wholly lay-dominated comes to us as very much of a surprise. Certainly no other group is as much interested in a county hospital as the medical profession.

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The Physical Fitness Number of THE JOURNAL, last month, was a smash hit, judging from the comments we have received, not only from Indiana but from other parts of the country as well. The "inside story" of this number began in Chicago, at the annual Secretaries-Editors' Conference last November. Following the paper by Doctor John W. Wilce, of Columbus, Ohio, there was quite some discussion. Doctor Julian Price, secretary of the South Carolina Medical Association, in his discussion said, "Every state medical journal in the country should get behind this Physical Fitness Program." Immediately thereafter the editor and the managing editor of THE JOURNAL of the Indiana State Medical Association retired to a cloakroom, and in a half hour had the special number pretty well worked out; got it going while our enthusiasm was at its peak, you know.

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Now more vital than at any time in the more than four decades we have been in the practice of medicine, the matter of personal health is the most important thing in the lives of our members. Practically all of us are going at top speed, all too often doing a bit of extra sprinting, and the strain is beginning to tell. One has but to read the obituary pages of *The Journal of the American Medical Association* to find that this is true; a brief survey of the several pages of such notices should make us pause for a moment and consider just what we, ourselves, are doing. Are we going too fast and, if so, what can we do about it? The very great majority of physicians now in active practice are men beyond middle age; thousands of them are in their sixties, a large number have passed the Biblical three-score-and-ten, while not a few are well over that age. They all want to do their bit, and the temptation is to do more than that—to take on just a few more cases. Better make a personal health survey and see just where you stand.

Pharmacopoeial Headquarters has a new home, a building for that purpose having been purchased in Philadelphia. The new address is 4738 Kingsessing Avenue.

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Dr. Patrick H. Weeks has entered upon his twenty-fifth year as the medical head of the Indiana State Prison, Michigan City. For many years, ever since the hospital for insane criminals has been located there, Doctor Weeks has been in charge thereof, in addition to his other duties. In the course of his many official years in the "big house," he has had an unusual opportunity to study criminology, as well as psychiatry, and has acquired a wealth of first-hand information.

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So now we have "National Posture Week," May 7 to 12. Physicians in general will have much to do with the many programs being arranged for that week. This, of course, fits in with the Physical Fitness Program now attracting so much attention throughout the nation, since posture has a lot to do with the general well-being of the individual. One but needs to walk down most any city street to observe cases in which posture seems to have been thrown to the wind. Too many of our young folk already are stoop-shouldered, while another group walks along in a most slovenly manner. Then, too, we have poor postures while sitting down, especially when reading. Legs curled up, sitting sideways in the chair, head cocked to one side—all of which definitely does not add to a physical fitness program. We wish that this posture business might be drawn to the attention of every citizen of the country, including the younger generation.

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Repercussions from our February cover page, depicting one of Indiana's fairest in the uniform of a service nurse, continue to appear, the latest being the cover page of the *Monthly Bulletin* of the Indiana State Board of Health, which carries the likeness of another of Indiana's fairest daughters —Miss Aida Louise Rice, daughter of our own Dr. Thurman B. Rice, editor of the aforementioned *Bulletin*. This charming girl gives much zest to an already good magazine, and we do not blame Editor Rice for wanting the world to know all about the young lady, who at present is a lieutenant in the Army Nurse Corps. However, we could not help remembering the old adage, "It's a long lane that knows no turnings," which has a direct application to the picture of Lieutenant Rice. Some years ago, at a state medical meeting, Doctor Rice and I happened to be engaged in conversation when our son, Doctor Jim, came up. After he had left, Doctor Rice remarked, "You know, I long have noticed that the young sons of our doctors are much better looking and far smarter than their dads." We are fully agreed that this aphorism fits the Rice family very well.

# President's Page

## CONTROL OF CANCER

From many reliable sources it appears that there is a genuine increase in the incidence of cancer, not only as regards special types of cancer, but as it applies to the disease in general. While it is true that the prolongation of life, to about the expectancy age of sixty, has resulted, paradoxically, in a far larger proportion of human beings reaching the years when the disease is most likely to strike, nevertheless the mortality toll from cancer has advanced year by year until it is now exceeded only by the heart disease group. More than 150,000 persons die each year in the United States from some form of cancer. Because of this appalling rate it is readily understood why individuals, as well as local and national governments, are concerning themselves in movements directed toward overcoming the prevailing attitude of hopelessness in its eradication.

Our limitations and ignorance as to the true cause and nature of this disease have been materially dispelled in the past two decades through an ever-increasing fund of information, supplied by individual research workers, concerning the characteristics of these growths and, to some extent, how they may be produced. But the true origin of cancer, the elementary factor which causes an orderly functioning cell to be transformed into a ruthless gangster, still remains unsolved. In addition, the effort to assemble all of the pertinent facts from the literature bearing on the cause of cancer becomes a herculean task, since it presupposes all encompassing knowledge of such subjects as biology, heredity, chemistry, pathology, metabolism, radiant energy, vitamins, enzymes, viruses, and the internal secretions of the ductless glands.

Thus, in the final analysis of all inquiries into the causation of cancer, we can state that much has been learned regarding the behavior and production of these tumors. It is established that the primary manifestations of cancer is an intracellular alteration in the tissues involved. They then become released from the orderly regulations incumbent upon normal cells and proceed in their destructive course. The initiating factor in this change is no longer essential to their continued growth and activity, and their propensity for banditry becomes a fixed characteristic which is transmitted to all their progeny. Ultimately then it appears that there are many substances within and without the body capable of furnishing the impetus to cell mutation, and to date practically all efforts have been directed toward the identification of those agents which are responsible for provoking these changes. The evidence of an hereditary willingness on the part of certain cells to partake in a destructive campaign of unrestricted growth does not differ essentially from individuals as a whole, and is perfectly compatible with the history of the world and all it contains. Such studies and experiments have produced a wealth of material revolving around the problem of cancer production; they have not furnished the answer to the question of why these changes occur. Perhaps the approach might be altered in the determination of the factors responsible for normal cell growth and activity, and in this manner a measure may be found to control the subversive activities of the gangster cells.

Plans for nation-wide stimulation of the people to become more cancer conscious are again being promulgated. The Women's Field Army will take the leading role, and too much credit cannot be given for the splendid efforts and results they have shown in their campaign to "Fight Cancer with Knowledge." They deserve and should receive all the support the medical profession can render in this very worthy cause.

In spite of the advances that have been made in the treatment of this condition, and the true fact that, if seen early, many of the victims of this disease can be cured, it nevertheless remains an unsolved problem in so far as its etiology is concerned. Slowly, however, and, we believe surely, our knowledge is accumulating, and as each added factor comes to light it becomes more and more evident that the cause of this disease is undoubtedly a very complex one—one which will not be determined by the discovery of any one specific element, but rather by a correlation of many factors acting together under suitable circumstances to produce the disease. Heredity, irritation, and undoubtedly endocrine dysfunction play prominent parts in so altering the chemical and growth activities of cells that they become malignant.

Let us see that the cancer educational program develops and spreads in Indiana. Its success in eradicating this disease, causing ten percent of all deaths, depends ultimately on you, the individual. The Womens' Field Army have made a glorious start, and they are not fighting alone. The medical profession is cooperating wholeheartedly. No one is compelled or drafted to fight in this war. We are all volunteers, and we need the help of everyone who is willing to join in this great crusade.

"Fight Cancer with Knowledge" and help save human lives!

N. K. Foster

# PLEA FOR A STATE LAY ORGANIZATION FOR CONSERVATION OF VISION

C. W. RUTHERFORD, M.D.

INDIANAPOLIS

Conservation of vision is not to be confused with such problems as finding work the blind can do, or with rehabilitating persons who have only recently become blind by disease, industrial accident, or war wounds. It is only incidentally concerned with stabilizing, without further loss, vision that has been materially reduced by disease or casualty. It is not restoration of vision, such as is experienced by the successful removal of a cataract or a transplant of the cornea. It is closely related to, but not strictly synonymous with, prevention of blindness by erecting safeguards and imposing safety devices in industry, in prohibiting personal use of fireworks and other explosives for amusement, and in prevention and control of eye disease.

Conservation of vision, in its broadest aspects, is comparable to conservation of public health. Typhoid fever has all but disappeared by individual immunization and public sanitation. The mortality from tuberculosis has been greatly reduced by sanitarium treatment and wise home management. Many other instances of disease prevention and control could be cited. Within the last half century longevity has been extended to such a degree that the new science of geriatrics is becoming a significant part of medical practice. All these advances indicate that it is not too imaginative to look forward to the time when blindness will be uncommon, but that economic blessing cannot be realized without plan and work.

Public consciousness of the importance of eyesight can be aroused through education, but progress is sometimes discouragingly slow when measured by popular response and cooperation. The beneficial results from vaccination against smallpox have been demonstrated for generations, but the facts have not yet completely overcome bigotry, ignorance, indifference, and procrastination. Ways and means to acquaint the public with conservation of vision will come through organized effort. The Red Cross had a modest beginning.

When alert parents notice anything unusual in the visual behavior of children, competent advice is sought without undue delay. Observant pediatricians detect visual defects in routine examinations. Pre-school tests to measure visual capacity are gaining adherents. Testing of vision on first entering school has become an established practice in metropolitan communities. Periodic testing by teachers and school nurses is a feature in many school systems. Watchfulness for early manifestations of eye diseases is also a part of the school program.

Once out of the grades, children are considered to be individually aware of poor sight or eye discomfort associated with disease; here supervision ends, and there is no more for the remainder of life. This period of adolescence through senility offers opportunity for conservation of vision by concerted study and effort.

Now, who should be interested? The oculist accepts responsibility for patients who consult him directly, or by referral. He cannot ethically canvass the community for persons who are neglecting their eyes or are indifferent to failing vision. The visiting nurse goes where sickness already exists. The social worker is mainly concerned with the indigent and inadequate. The Public Health Service has not yet gotten around to this subject, comprehensively, even though it is of public importance.

Experience has shown that a lay organization provides the best means to arouse public interest and accomplish the greatest good. Oculists and public health nurses are valuable assets in an advisory capacity. Specially-trained social workers are necessary to solve technical problems and carry out routine work.

The first requirement would be the organization of a state lay committee, with later addition of local committees as the program develops. Such a state committee cannot accomplish much if composed of persons who merely seek diversion. Maximum success will depend upon members who have (1) a consciousness of the importance of the subject, (2) sufficient interest to study it, and (3), the will to work for success. Some of the problems to be considered are found in other papers published in this issue of THE JOURNAL.

The first duty of the state committee would be to plan for the financing thereof. This has been done for the Red Cross, Crippled Children's Division, anti-tuberculosis campaigns, the Illinois Society for the Prevention of Blindness, and other movements of public interest. It should be feasible for conservation of vision in Indiana. The degree of financial support will determine how much can be accomplished—and how soon.

# THE BOLTON LAW AND ITS RELATIONSHIP TO THE PATIENT*

JANE E. TAYLOR †

CHICAGO

Questions about the United States Cadet Nurse Corps often arise. For example, What is the relation between the Cadet Nurse and Nursing Service? Is this a program that stresses education only? Is the patient the Cadet Nurses' first consideration? The American Hospital Association has recently given the answer to all these questions with the statement, "The United States Cadet Nurse Corps has prevented the collapse of civilian nursing."

Even those leaders in hospital and nursing fields who worked closely with the development of the program could not estimate or anticipate the magnitude of the results. Many of you are aware thereof from personal experience of the many benefits already apparent. The splendid cooperation given by medical and nursing groups has been responsible in great part for the success of the program.

While the Bolton Act is administered by the United States Public Health Service, the schools have the responsibility for the education of students and hospitals for the nursing care of patients. Details are planned by the school or hospital, and the programs approved by the State Board of Nurse Examiners. Our concern is the health and education of the nurse and the standards of nursing care given patients.

Nurses as professional people have begun to think along new lines—improvement in educational procedures. In order to make graduate nurses available more rapidly, preparation had to be accelerated. This is in line with the action taken in medical schools to accelerate medical education. I understand that the content of seventeen weeks was given in fourteen weeks at the Indiana University School of Medicine. This problem of acceleration was tackled by the State Board of Nurse Examiners, and assistance given to schools in methods of planning and integrating the theory and practice of nursing to condense it into thirty months rather than thirty-six. Acceleration is one of the requirements of the Cadet Nurse Corps program administered by the United States Public Health Service. Most states require three years training, and so the period has been divided into the Pre-cadet Period—first nine months, the Junior Cadet period —next twenty-one months, and the Senior Cadet Period—last six months.

At present, approximately eleven hundred schools of nursing are receiving federal allotments which provide scholarships for students and assist schools in financing their program. The country needed more nurses faster, and the Bolton Act was passed for that purpose. Schools have done a prodigious job of acceleration. Two years ago we would not have thought it possible to condense nurse education into thirty months without dehydrating it to the point where it would have been unrecognizable, yet today this has been accomplished in practically all the country's schools of nursing. Acceleration has stimulated our nursing schools to greater achievements. They have analyzed patient care and reviewed school curricula in an attempt to eliminate undesirable repetition and relate factual data to the patient situation.

Greater emphasis has been given to ward teaching or bedside instruction, which has improved patient care with the emphasis on the *needs* of individual patients, as they experience certain disorders or physiological phenomena. Many of you have assisted with this teaching as you give clinics or write patients' histories or progress notes. Every written order contributes to the ward teaching and understanding of patients' needs.

The goal of better care for each patient in a war setting of making every class meaningful has assisted schools in maintaining those high standards for which American Schools of Nursing have long been famous.

With the increase in student enrollments in schools of nursing, it has been necessary in many cases to seek additional clinical experience in affiliating institutes. This is an excellent device for securing required experience as well as spreading nursing service to other hospitals, some having no schools of nursing. It is desirable that affiliation be made available to all students in the limiting services rather than just a few, because of the broadened experience and the spreading of nursing care. Many schools have included one or more of the following in the basic programs: Tuberculosis, Psychiatry, Communicable Disease, and Public Health Nursing. The war has pointed up dramatically the importance of highly-skilled professional nurses in our scheme of health and medical services. We all know that experience has no substitute, but experience must be founded on a sound and thorough educational background. The medical profession has progressed scientifically and gained in prestige over a long period of time. The medical profession demands educational requirements of high calibre as a background for experience. The M.D. so equipped has every right to expect the nurse who is working *for* and *with* him to be similarly equipped, in order that she might be of greater assistance to him, whether her duties are in surgery or at the bedside.

The best nursing care possible can be provided

* Presented before the Secretaries' Conference of the Indiana State Medical Association, at Indianapolis, on January 21, 1945.

† Nurse Education Consultant, Division of Nurse Education, District Office (Chicago), United States Public Health Service.

only when our institutions and agencies are staffed with nurses who are highly skilled and who have a sound understanding of the principles underlying these skills. Our student nurses, and particularly our Senior Cadets, are meeting the emergency and meeting it well. This will be of inestimable benefit in developing a large pool of qualified graduate nurses. It is this pool upon which hospitals and nursing services may draw in postwar years, as well as for present needs.

Enlarged enrollments also allow nursing schools to distribute their Senior Cadets more widely. Last year almost eleven thousand Senior Cadets were available for assignment during this supervised practice period. Twice that number will enter this final phase of their education before July 1, 1945. Students may request transfer to federal hospitals the last six months; and in case all wish the experience, the five federal services have agreed to take not more than 50 per cent of the Senior Cadets in any one school. It may interest you to hear that up to the present time only 1,931 of the eleven thousand Senior Cadets have been assigned to federal hospitals. The greater number have remained in their home hospitals or have gone to other civilian institutions or agencies. The figures on the present and anticipated number of Senior Cadets indicate that this group is destined to fill an increasingly-important place in the nursing needs of the country.

Excellent plans for the use of Senior Cadets have been set up by rural and psychiatric hospitals, public health agencies, and by a few tuberculosis sanitaria. Home hospitals are using Senior Cadets as student-assistant head nurses, student-assistant instructors, and in many similar positions in operating rooms, delivery rooms, and clinical divisions.

Since the inception of the Cadet Corps, our hard-pressed hospitals have benefited considerably by the services of more than nine thousand Senior Cadet Nurses, and the number continues to increase.

Student nurses have grown in number from eighty-seven thousand student nurses in 1941 to about one hundred twenty-five thousand today. If we are to continue to meet the requirements of your hospitals, as well as continuing demands for nurses from public health and industrial services, and the increasing military need, we must enroll an additional sixty thousand new students this year. We look to you as recruiters of students for schools, for the word of the physician carries great weight with the families of prospective students.

Nurse education provided by schools today is the hope of meeting America's present and future nursing needs—the hope of better nursing service to civilian and military groups alike.

War has had very beneficial results for the development of medical science. The Bolton Act, an emergency measure which was enacted to meet wartime nursing needs, has equally benefited the nursing care of our country.

War also has re-emphasized the need of cooperaation—only by working together can we achieve our goals. In whatever plans we make for the future of nursing, we must be guided by this principle. The consumers of nursing service know the kind of nursing they want in their homes and hospitals. The medical profession and the hospitals know the kind of nursing service they want and need for their patients. Nurses know the kind of nursing service that best represents their profession. Nurse educators know the techniques of preparing nurses to give the kind of nursing service required. Thus, the public and the hospital, the nursing and medical professions must work together to make a plan for the future which will fit in against the backdrop of over-all plans for health and medical care, a future in which it is hoped to establish standards of living surpassing all previous human experience.

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# Deaths

**Claude William Asbury, M.D.**, of Hymera, died March first at the age of sixty-eight. He was a graduate of the Illinois Medical College, in Chicago, and had practiced for forty years at Hymera and Terre Haute.

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**Eugene Schumaker, M.D.**, of Rensselaer, died of a heart attack on March twelfth. He was thirty-nine years of age. Doctor Schumaker was a graduate of the Rush Medical College, in Chicago, in 1934. He was a member of the Jasper-Newton County Medical Society, the Indiana State Medical Association, and the American Medical Association.

**Edmund R. Gaddie, M.D.**, of New Albany, died March eleventh at his home. He was seventy-five years of age. Doctor Gaddie was graduated from the Louisville National Medical College, in 1892.

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**Thomas Francis Cotter, M.D.**, of East Chicago, died suddenly on March twelfth, at the age of sixty-eight. He was a graduate of the Indiana University School of Medicine, in 1902. Doctor Cotter was a member of the American College of Physicians, the Lake County Medical Society, the Indiana State Medical Association, and the American Medical Association.

**Ivan Webster Riggins, M.D.**, of Indianapolis, died March fifteenth at the age of seventy-one. He was a graduate of the University of Louisville School of Medicine, in 1907.

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**Robert Hite Egbert, M.D.**, of Martinsville, died March twenty-second, at the age of sixty-one. He was a graduate of the Indiana University School of Medicine, in 1909, and was medical director of the Home Lawn Sanitarium. Doctor Egbert was a member of the Morgan County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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**Louis Burckhardt, M.D.**, of Indianapolis, died March nineteenth from injuries suffered in a fall. He was eighty years of age. Born in Switzerland, Doctor Burckhardt was a graduate of the Universitat Zurich Medizinische Fakultat, in 1889, and came to Indianapolis in 1893, where he completed more than fifty years of medical practice. He was Professor Emeritus of Obstetrics at the Indiana University School of Medicine; was a member of the Indianapolis (Marion County) Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

**Isaac Newton Turner, M.D.**, of Indianapolis, died March thirty-first after a year's illness. He was fifty-five years of age. Doctor Turner was a graduate of the Maharry Medical College, in Nashville, Tennessee, in 1913.

* * *

**Maxwell Herschleder, M.D.**, of Gary, died instantly on March ninth, when his car was struck by a passenger train. He graduated from the Illinois Medical College, in Chicago, in 1910, and was engaged in industrial practice. He was the head of the Lincoln Hospital, in Gary. Doctor Herschleder was fifty-nine years of age. He was a member of the Lake County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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**Lon C. Bice, M.D.**, of Edinburg, died March fifteenth at his home. He was seventy-four years of age. Doctor Bice graduated from the Bellevue Hospital Medical College, in New York, in 1897, and had practiced in Edinburg for forty-six years. He served as a captain in the first World War. Doctor Bice was a member of the Johnson County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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## DEATHS OF INDIANA PHYSICIANS IN 1944

(M) Member I.S.M.A.; (H) Honorary Member; (R) Retired

| NAME | AGE | DATE OF DEATH | ADDRESS | CAUSE OF DEATH On Death Certificate |
|---|---|---|---|---|
| Miller, Harry | 76 | Jan. 2 | Morristown | Cerebral hemorrhage |
| Milligan, James W. (H) | 85 | Jan. 5 | North Madison | Postoperative respiratory failure |
| Saunders, Joel E. | 71 | Jan. 11 | Grasscreek | |
| Williams, William H. (H) | 75 | Jan. 13 | Lebanon | Intestinal obstruction and paralytic ileus |
| Miller, Ephraim B. | 78 | Jan. 16 | Fountaintown | Myelogenous leukemia |
| Given, Walter S. | 65 | Jan. 22 | Indianapolis | Carcinoma of the prostate |
| Kan, Alexander M. (M) | 61 | Jan. 31 | Gary | Carcinoma of urinary bladder and prostate |
| *Miller, Harry D. (Capt.) (M) | 35 | Feb. 2 | Shelbyville | Boiler explosion in service in Africa |
| Fackler, Volney N. (M) | 71 | Feb. 2 | Richmond | Coronary occlusion. Arteriosclerosis |
| Foor, J. Delbert | 72 | Feb. 4 | Terre Haute | Lymphatic leukemia |
| Goar, Charles S. (H) | 78 | Feb. 4 | Indianapolis | Myocardial degeneration and asthma |
| Cowing, Hugh A. | 83 | Feb. 9 | Muncie | Carcinoma of the prostate with spinal metastasis |
| Dugdale, Richard B. (H) | 75 | Feb. 12 | South Bend | Cerebral emboli. Arteriosclerosis |
| Pritchett, Willis S. | 85 | Feb. 16 | Evansville | Adenocarcinoma |
| Swan, Dudley H. (M) | 75 | Feb. 20 | Plainville | Cerebral hemorrhage |
| Graham, Paul C. (M) | 64 | Feb. 25 | Columbus | Carcinoma—postoperative |
| Bowers, Eugene P. | 66 | Mar. 1 | Vincennes | Bronchopneumonia. Pulmonary infarct. Chronic myocarditis. Chronic malaria |
| Ferree, Isaac | 89 | Mar. 1 | Livonia | Cerebral hemorrhage. Organic heart disease. Arteriosclerosis |
| Thompson, John A. | 85 | Mar. 1 | Brookville | Coronary disease |
| Searcy, Benjamin N. | 66 | Mar. 6 | Rising Sun | Cerebral hemorrhage |
| Lunsford, Charles B. | 72 | Mar. 7 | Goshen | Chronic myocarditis. Diabetes mellitus. Cerebral thrombosis |
| Tabor, Frank A. (M) | 71 | Mar. 8 | Terre Haute | Hemiplegia. Arteriosclerosis. Hypertension. Coronary heart disease |
| Chappell, Ralph S. (M) | 64 | Mar. 12 | Indianapolis | Cardio-respiratory failure, auricular fibrillation. Mycosis fungoides |
| Burkhart, Thomas A. | 71 | Mar. 17 | Jasonville | Cerebral hemorrhage. Essential hypertension |
| *Wakeman, Colonel Frank B. | 48 | Mar. 17 | Valparaiso | Coronary occlusion |
| Smith, George F. (M) | 69 | Mar. 20 | Lawrenceburg | Edema lungs. Acute congestive heart disease. Hypertension |
| Beck, Flavius J. (H) | 81 | Mar. 27 | Columbus | Psychosis with cerebral arteriosclerosis. Hypertensive heart |
| Billman, James M (H) | 79 | Mar. 27 | Sullivan | Chronic myocarditis |
| Beeson, Roscoe H. (M) | 53 | Mar. 30 | Muncie | Diabetes Mellitus |
| Stamper, Warren L. (M) | 73 | Apr. 2 | Indianapolis | Cerebral hemorrhage. Diabetes Mellitus |
| Cunningham, Harley L. | 82 | Apr. 11 | Ashley | Suicide. Gunshot wound of head |
| McFarlin, John T. (H) | 76 | Apr. 18 | Williams | Chronic myocarditis |
| Bowen, Joseph F. (M) | 73 | Apr. 21 | Rushville | Cerebral hemorrhage. Hypertension |
| Woolery, Homer | 71 | Apr. 22 | Bloomington | Coronary thrombosis |

* Died in Military Service.

| NAME | AGE | DATE OF DEATH | ADDRESS | CAUSE OF DEATH On Death Certificate |
|---|---|---|---|---|
| Stanton, Harmon L. (M) | 50 | Apr. 23 | Evansville | Cerebral hemorrhage. General arteriosclerosis |
| McDonald, Angus C. (H) | 79 | Apr. 23 | Warsaw | Carcinoma of stomach |
| Holley, Albert C. (M) | 71 | Apr. 26 | Attica | Myelogenous leukemia. Hypostatic pneumonia |
| Rariden, Charles E. | 87 | Apr. 29 | Bedford | Coronary thrombosis |
| Smith, George C. (M) | 80 | May 2 | Poseyville | Lobar Pneumonia. Angina pectoris |
| Eisenbeiss, Charles M. | 73 | May 3 | South Bend | Nephritis, Prostatic hyperplasia. Polyposis of bladder |
| Long, Victor F. | 52 | May 7 | LaPorte | Pulmonary embolism following amputation of leg |
| Innis, Robert E. | 83 | May 9 | Marion | Arteriosclerosis. Terminal pneumonia |
| Reid, Carrie Turner | 64 | May 11 | Indianapolis | Intestinal obstruction |
| Shoemaker, James B. (M) | 59 | May 13 | Miami | Coronary thrombosis |
| Eichel, Sidney J. (M) | 67 | May 14 | Evansville | Myocardial degeneration and cardiac asthma |
| Eley, Lorenzo D. (H) | 88 | May 14 | Plymouth | Pulmonary edema. Chronic arteriosclerosis. Pleural effusion |
| Siegmund, Edwin J. | 68 | May 25 | Wabash | Congestive heart failure. Rheumatic endocarditis |
| Andrews, John R. | 72 | May 25 | Bedford | Chronic myocarditis |
| Kepert, Andrew E. | 67 | May 26 | Hammond | Carcinoma of liver |
| Melton, Onis O. | 59 | June 4 | Lowell | Coronary thrombosis |
| Van Cleave, Maurice B. (M) | 69 | June 11 | Terre Haute | Organic heart disease and coronary sclerosis |
| Cruikshank, Orris G. | 83 | June 17 | Terre Haute | Cerebral hemorrhage. Arteriosclerosis. Senility |
| Brubaker, Elias H. (M) | 63 | June 28 | Flora | Ruptured bladder following prostatectomy |
| Emerson, Ralph W. | 74 | July 3 | Owensville | Coronary thrombosis. Hypertension |
| Price, Jesse D. (M) | 72 | July 3 | Michigan City | Cerebral hemorrhage. Hypertension |
| *Smith, Martlin P. (Lt. Com.) (M) | 36 | July 5 | Muncie | Auto wreck |
| Caylor, Charles E. (M) | 74 | July 5 | Bluffton | Auto wreck. Fracture of skull |
| Tourner, Frank F. (M) | 85 | July 6 | Bloomington | Hypostatic pneumonia. Arteriosclerosis |
| Gibbons, John A. | 71 | July 6 | Mitchell | Carcinoma of rectum |
| Taylor, Basil M. (M) | 74 | July 10 | Portland | Coronary occlusion |
| Taylor, James H. (H) | 81 | July 23 | Indianapolis | Chronic myocarditis |
| Gwaltney, Bertis C. (M) | 50 | Aug. 10 | Fort Branch | Coronary thrombosis |
| McConnell, George G. | 78 | Aug. 11 | Mooresville | Hypertensive heart. Diabetes mellitus |
| Williams, Francis M. (M) | 57 | Aug. 18 | Anderson | Auto train wreck |
| Morgan, Charles A. (M) | 67 | Aug. 31 | Indianapolis | Coronary thrombosis |
| Martin, Emma E. | 74 | Sept. 3 | Otterbein | Carcinoma of stomach and liver |
| Dyar, Edwin W. (M) | 64 | Sept. 11 | Ossian | Hypostatic pneumonia. Chronic myocarditis |
| Hodges, Vernard R. | 61 | Sept. 14 | Indianapolis | Coronary occlusion |
| Stroube, Charles N. (M) | 75 | Sept. 17 | Roachdale | Cerebral hemorrhage |
| McAuliffe, Dennis L. (H) | 79 | Sept. 18 | North Vernon | Myocardosis. Auricular fibrillation |
| Jones, Thomas M. (M) | 67 | Sept. 19 | Anderson | Congestive heart failure. Rheumatic heart |
| Zaring, Everett T. (M) | 61 | Sept. 20 | Terre Haute | Cerebral hemorrhage. Pernicious anemia |
| Cameron, John F. (H) | 89 | Sept. 20 | Hamilton | Myocardial failure. Senility |
| Metcalf, Henry C. (M) | 56 | Sept. 23 | Connersville | Bronchopneumonia. Hypertensive vascular disease |
| Barnhill, William A. D. | 84 | Sept. 25 | Laotto | Bronchopneumonia after fall |
| Fortune, James L. | 64 | Sept. 26 | Terre Haute | Cerebral hemorrhage. Acute cardiac dilatation |
| Grishaw, Harry E. (M) | 71 | Sept. 28 | Tipton | Chronic nephritis. General arteriosclerosis |
| Mottier, Guilford D. | 71 | Sept. 28 | Patriot | Coronary disease |
| Doneghy, Charles J. | 45 | Oct. 2 | East Chicago | Coronary occlusion |
| Wells, Milton M. (M) | 73 | Oct. 12 | Fairland | Cardiac decompensation. Epithelioma of left ear |
| McDonald, Earnest C. (M) | 42 | Oct. 23 | Indianapolis | Uremia. Amyloid kidney |
| Sabin, Albert E. (M) | 70 | Oct. 26 | Dana | Angina pectoris. Arteriosclerosis |
| Copeland, Robert M. (H) | 83 | Oct. 28 | Vevay | Cerebral hemorrhage. Arteriosclerosis |
| Zink, Clyde M. (M) | 57 | Nov. 7 | Clinton | Heart disease. Acute nephritis |
| Bonifield, William D. | 82 | Nov. 8 | Warren | Uremia. Aneurysm right popliteal artery |
| Leeds, Frank R. | 71 | Nov. 16 | Ridgeway | Pneumonia |
| *Rafferty, Michael A. (Major) (M) | 41 | Nov. 24 | Elkhart | Killed in Belgium |
| Reagan, Linley M. (M) | 72 | Nov. 28 | Kokomo | Coronary embolism |
| Kemp, Joseph W. | 88 | Nov. 30 | Roanoke | Influenza. Pneumonia. Cerebral hemorrhage |
| Karstetter, William B. | 84 | Dec. 2 | Indianapolis | Arteriosclerosis |
| Meloy, John M. | 82 | Dec. 2 | Greenfield | Coronary thrombosis |
| Vogt, A. William | 88 | Dec. 3 | Batesville | Carcinoma of the rectum |
| Hall, Walter A. (M) | 64 | Dec. 9 | New Albany | Coronary heart disease |
| Garshwiler, William P. (H) | 76 | Dec. 10 | Indianapolis | Cerebral hemorrhage |
| Corbin, Edward M. (H) | 76 | Dec. 12 | Sullivan | Coronary occlusion |
| Shook, Benjamin O. | 74 | Dec. 13 | Spencerville | Auto accident |
| Barcus, C. E. | 64 | Dec. 20 | Indianapolis | Bilateral tuberculous pneumonia |
| Williams, George T. (H) | 79 | Dec. 30 | Crawfordsville | Cerebral apoplexy. Right hemiplegia |
| Rover, Elmo R. (M) | 69 | Dec. 31 | North Salem | Pericarditis. Myocarditis |

* Died in Military Service.

## RADIO CALENDAR

"YOUR HEALTH IN WARTIME"

Hear these broadcasts each week:

Indiana State Medical Association—Doctor Goodhealth—Monday, 3:30 P.M., WFBM, Indianapolis

Elkhart County Medical Society—Wednesday, 4:30 P.M., WTRC, Elkhart

Vigo County Medical Society—Thursday, 12:15 P.M., WBOW, Terre Haute

St. Joseph County Medical Society—Friday, 1:45 P.M., WSBT, South Bend

Howard County Medical Society—Friday, 6:30 P.M., WKMO, Kokomo

Vanderburgh County Medical Society—Saturday, 10:00 A.M., WGBF, Evansville

# Military News

## CAPTAIN HARRY MERRILL BROWN RETURNS FROM JAP PRISON

We salute Captain Harry Merrill Brown, of Indianapolis, who was a prisoner of the Japanese in the Philippines for almost three years, and who was in the first group to be returned to the United States, on March fifth.

*Captain Brown*

Captain Brown graduated from the Indiana University School of Medicine in 1939, and spent two years at the Indianapolis City Hospital before entering the Medical Corps on April 1, 1941. He was stationed at Fort McKinley, on Bataan, with General Hospital No. 1, which fell into the hands of the Japanese on April 9, 1942. He was released by the Sixth Rangers, at Cabanatuan, on January thirtieth.

His wife, Lieutenant Irene Phillips Brown, who has served as a flight nurse in the China-Burma-India Theatre, also returned shortly after his release, and we welcome them back in Indiana.

No one can tell the story better than Captain Brown, and we are, indeed, grateful for his message giving us a direct account of some of his experiences during his imprisonment:

"In August, 1941, I went to the Philippines, at which time I was assigned to the McKinley Station Hospital, with Colonel James Duckworth, who also was formerly of Indianapolis and Martinsville. At the time the war broke out, all the available doctors were sent into Manila to establish the "Manila Hospital Center." This assignment lasted only ten days, during which time about seven large hospitals were set up, but these hospitals were never used by the Americans, inasmuch as we were all ordered to Bataan and Corregidor. Colonel Duckworth and I again were together in General Hospital No. 1, on Bataan. This was the hospital which was bombed several times. We surrendered on April 9, 1942. The Japanese allowed us to stay and care for our patients until July second, at which time all our patients were evacuated to Manila, and we were sent to Camp O'Donnell as a unit, and allowed to take most of our equipment with us. There we established five one-thousand-bed hospitals, under the direction of Colonel Duckworth, and took care of the Filipinos remaining at that camp. When these men had first come to O'Donnell, together with the Americans, in April, there were approximately fifty-five thousand Filipinos, but more than half of them had died of starvation, malaria, and dysentery. The death rate was still high when we arrived, but it came down rapidly when medical care was given to them. Seven months later we were sent to the American camp which was known as Camp No. 1, at Cabanatuan. This was the largest concentration camp for American prisoners-of-war, and was used as a central supply of men for work details out over the islands. These details were sent out in groups of two and three hundred men, and sometimes as many as six hundred, to work on airports, roads, loading and unloading of ships, and in handling of war supplies for the Japanese. At Camp No. 1 there was a large farm of approximately two hundred fifty acres. All work done on this farm was hand labor, performed by the Americans. Company grade officers and enlisted personnel were treated alike. On this farm we raised comotes (a type of sweet potato), casava—also a carbohydrate, corn, radishes, onions, and cucumbers. Much of the produce was used by the Japanese, and we were allowed to use some of the comotes, casava, and corn. These three items made up most of the supplementary food to our diet of rice three times a day. There was a great loss of weight among all the men. I did not lose as much weight as some, but probably as much as most of them. When I came out I weighed 115 pounds, regained 35 pounds in the first six weeks after release, and by this time I have gained a total of 45 pounds, but am still a little underweight.

"In 1943 the American Red Cross was able to get a few small boxes of food for each man through to us, and some drug supplies which were a godsend. At this time we were badly in need of amebacides, sulfathiazole, quinine, and drugs for general treatment. While we never had very much of any of these, we were indeed thankful for what we did receive. Beginning in September, 1944, the Japanese again started transferring large details of men to Japan. They left 511 men at the camp, hospital patients who were considered too sick to travel. I was one of the fortunate eight doctors who were left there to take care of these men. We were released on the night of January 30, 1945, by the Rangers of the Sixth Army.

"The other three Indiana doctors who were in the

Philippines at the outbreak of the war were Lloyd H. Goad, Basil B. Dulin, and Nelson N. Kauffman. These three men had been sent to Japan prior to February, 1944.

"For official reasons there are many things which I am not free to discuss. However, I hope in the near future to write an article on diseases as they existed in the prison camps during the three years of starvation."

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Now on duty at the United States Naval Hospital, Lieutenant Commander Russell A. Flack, of Lafayette, writes that he has been transferred there after a couple years' stay at Coco Solo, Canal Zone, and a short period of duty at Bunker Hill, Indiana.

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From Belgium, Captain Paul A. Jones, of Lyons, writes as follows: "Received another of the most interesting Journals in the business. It is one of the things that keeps all of the Hoosier doctors in touch with home. Any word from home, however slight, means much to all of us here.

"Howard Romack, class of '38, was attached to our unit with a surgical team, and has been the only Indiana doctor I've seen since I've been overseas. John Woner, of Linton, stopped in to see me one day, but I missed him, as I was off visiting the submarine pens." Captain Jones is on duty with an evacuation hospital.

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Major Marion W. Hillman, of South Bend, has gone back to Hawaii after spending three months on Guam. He states that he was glad to get back, and he is now assigned to the Central Pacific Base Command and has been given temporary duty in surgery at a general hospital there. He says that the post is particularly nice and comfortable, and that they have a good group. There is sufficient work coming back from the forward area to keep them fairly busy, and he is glad to have a chance to do some real work again, and get the rust brushed off.

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Captain Jack L. Eisaman, of Bluffton, has written us as follows: "This is just a brief message to assure you that I appreciate THE JOURNAL, 'Med-Soc,' and any other information you have to give us. It sure is interesting to read about the other fellows in the Service—where they are and what they are doing.

"Lieutenant Colonel Hawthorne Wallace, of Crawfordsville, is our chief of surgery. His three nurse assistants are with us, and our chaplain and another nurse are from Indiana, so we are quite an Indiana group.

"I am in charge of a general medical ward, take care of the isolation unit, take care of the sick nurses, and have the dispensary and outpatient clinic one week out of three. Needless to say, I am busy, but happier that way." Incidentally, Captain Eisaman has just recently received his promotion as a captain.

After spending two years in active service in the Pacific area, Major Paul L. Long, of Anderson, has returned to this country, and is at the Auburn General Hospital, at Auburn, California. He expects to return to Anderson within a few weeks. Major Long has been at Guadalcanal, New Georgia, and the Palau Islands.

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Following is a most entertaining letter written by a *staunch* Navy doctor, Commander Harold E. List, of Marion:

"Got my feet back on the good earth once more, and am S.M.O. at this Marine Corps Air Station. Have been called a lot of things, but guess that now I'll have to get used to being called lieutenant colonel by the Gyrenes here. We have a wonderful dispensary—at least it looks good after being cramped up in a ship's sick bay for the past several months. This is all Marine here except for just enough Navy to see that the place is run right. Everyone is doing a swell job out our way, because we feel that the closer we get to Tokyo, the closer we get to home."

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Major Harry S. Rabb, of Indianapolis, has become quite well-known in a little village in Belgium, close to the American camp where he is stationed. A little boy, playing in a field, attempted to pick up what appeared to be a harmless shell casing. Booby-trapped by the Germans, the shell exploded on touch, mangling the child's hand. As there were no doctors in the village, the boy's father rushed him to the American camp, where Major Rabb swiftly amputated the mangled fingers and stopped the bleeding that might have cost the child his life. The boy revisited the dispensary several times, and on each visit carried away pocketfuls of soldiers' candy ration. Soon others came—a small boy badly scalded, a girl with an infection, and others. Major Rabb has been overseas for more than two and a half years, and is group surgeon with an Air Force service command.

*Major Rabb caring for a Belgian booby-trap victim.*

Lieutenant Colonel Joseph H. Clevenger, of Muncie, has been awarded the Bronze Star for meritorious service. Colonel Clevenger, who has been commanding officer in charge of a field hospital, left his unit in Belgium recently because of injuries, and has been returned to this country for treatment. The field hospital of which he was in command also has been awarded the meritorious service unit plaque.

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A recent letter from Captain James M. Alexander, of Argos, states that he has arrived overseas, and is now on duty with a general hospital in northern France. Captain Alexander writes:

"I am chief of the neuropsychiatric section here. There are two fellow Indianians also in this hospital, Major John Masters and Captain B. V. Klain, both of Indianapolis." Captain Alexander was previously stationed at the Dornell General Hospital, in Danville, Kentucky.

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We take the privilege of quoting a letter published in the St. Joseph County Medical Society *Service Bulletin*, written by Major Donald Grillo, of South Bend:

"If things work out as they should, this year bears possibilities of my return to the States for a visit. I feel that the war with Japan will last a long time. As you well know, things in China have not been going so well. The Chinese are weak in many ways and will require much help now and for a long time after the war. It is essential that they have someone who is strong and fair to oversee them for a long time, until they are able to carry on independently. I believe America is that logical one. Things here have been changing a good deal, and we can't be certain of our immediate future. I would like an opportunity to visit the coast of China and some of the larger cities before I return. We are accustomed to this place now and are getting by pretty well."

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A former Indianapolis City Hospital intern, Lieutenant Max Long, is rapidly becoming a legend among the Marines, according to a dispatch from a Marine Corps public relations officer at Iwo Jima. The dispatch states: "You cannot walk far along the pock-marked beaches of Iwo Jima today before someone will tell you in admiration and unbelief that 'Maxie did it again.' Dr. Long came ashore on D-day on one of the bloodiest of Pacific beachheads. Within twenty-four hours every doctor in his command had been knocked out of action, and half the corps serving with him had become casualties. He carried on alone and worked without sleep. There were twelve-hour stretches in which he was never without a scalpel in his hand. The gallant Indiana doctor sent more than a hundred of the Marines off the beach, giving them a fighting chance to live."

Lieutenant Long has also seen much action in the Marshall Islands, Saipan and Tinian, and now the Volcano Islands.

Lieutenant Arthur J. Roser, of Arcola, has returned to the United States after twenty-one months of duty in the South Pacific. He headed a surgical team aboard an LST, and states: "I handled a lot of casualties. There wasn't a 'beefer' in the lot. Those boys have a lot of fortitude and nerves of steel—that is why we are winning in the Pacific. Among the painful wounded aboard the LST on which I served during the Leyte and Mindora invasion in the Philippines were some who lost legs or arms, yet there were no 'gripers.'"

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Few people can write a letter in such a fascinating manner as Captain Casimir L. Libnoch, of South Bend, whose last letter came from France. We quote the following one from the St. Joseph County Medical Society *Service Bulletin:*

"The Supply Officer caught up with my battalion moving along a railroad bed and dished out the Thanksgiving turkey in a pouring rain. I ate the bird, crouching under a raincoat, consoling myself with the thought that the squareheads suffered much more. That night we sneaked through and got in behind the enemy. Came dawn, and we marched into our first objective, waking up thirty-five Krauts to announce a new day for them. That turkey kept me going twenty-odd miles, and I was reluctant on washing off particles from my denture twenty-four hours later. Right now I am reclining on a feather tick following a steak dinner. The floor is strewn with chocolates and dressings, snacks and Thomas splints, and my men are lying prostrated, puffing on their Christmas cigars. Last time I saw Ray Nelson was in Highway 18, Southeast of Battipaglia, last July."

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Five members from the office of Dr. Carl G. Miller, of Fort Wayne, are now with the Medical Corps of the Armed Forces. They are Major Carl G. Miller, Captain John H. Kilmer, Captain Donald S. Ladig, Lieutenant Edna Wise, and Lieutenant Mary Woodhull.

Major Miller, with the Third Army in France, is in command of a surgical hospital unit attached to a field hospital. The chief aim of the hospital is to bring facilities for the performance of major surgery, in all its phases, as far forward as possible. He has received the Bronze Star for meritorious service.

Captain Kilmer was the first medical officer in his division to be awarded the Silver Star for gallantry in action in the battle for Rome. He has also participated in the invasion of southern France, and received his baptism of fire in the invasion of Sicily, Italy, and the Anzio beachhead. He also holds the Combat Infantryman's Badge.

Captain Ladig has been in service since July, 1942, and is stationed at the Greenwood, Mississippi, Army Air Base.

Lieutenant Wise is on duty with the Army Nurse Corps in a field hospital in Belgium, and Lieutenant Woodhull, a Navy nurse, is assisting in a rehabilitation center in England.

## THE INDIANA GENERAL HOSPITAL

The Indiana General Hospital, recruited and sponsored by the Indiana University Medical Center and largely staffed by Hoosier doctors, dentists, nurses and technicians, has become the first major Army medical installation to be established in Germany, according to a press announcement made by Headquarters, Communications Zone, European Theatre of Operations. (Because of censorship regulations the hospital number can not be published at this time.)

The ETO announcement, which is the first official word received from the Indiana hospital unit in months, says that the unit is now established in the facilities of a former German army hospital. Normally a rear echelon institution, the Indiana General Hospital, according to the announcement, moved up from Belgium to help relieve another over-burdened field hospital, and in its first day of operation, even before the medical staff had time to unpack their duty uniforms, had evacuated 1,200 front-line casualties.

Opening in its new location with a capacity of one thousand beds, the hospital, under the command of Colonel Cyrus J. Clark, of Indianapolis, added five hundred beds in its first two days, a period in which the entire staff was on twenty-four-hour emergency duty. In the abandoned German army hospital quarters the staff members discovered a quantity of new and unused German x-ray equipment.

"We found a fluoroscope which will permit four exposures on one film, which is a relatively new development, and is double the capacity of most of those made in America," Lieutenant Colonel Charles Ingersoll, of Grand Rapids, Michigan, head of the x-ray department, is quoted as stating in the Army announcement.

The Indiana General Hospital was activated at Camp Bowie, Texas, in January, 1943, went to England in September, 1943, and operated two hospitals in the Midlands section of England. On D-day it sent dispensary teams to the invasion ports, where they treated many of the first casualties returned from France. The unit moved to Normandy in July and operated from tent headquarters.

The Army's announcement said that those now assigned to the hospital as department heads include Lieutenant Colonel Frederick D. Cheney, Indianapolis, medical service; Major Russel D. Hippensteel, Indianapolis, communicable diseases; Major Brandt F. Steele, Indianapolis, neuropsychiatry; Captain William D. Gambill, Indianapolis, gastro-enterology; Captain William B. Rossman, Indianapolis, general medicine; Captain Charles A. Everett, Indianapolis, and Lieutenant Colonel Carl S. Culbertson, South Bend, dental service; Major Charles L. Mahoney, Terre Haute, eye, ear, nose and throat service; Captain John R. Haslem, Terre Haute, neurosurgery; Major Robert L. Amos, New Castle, urological; Captain J. Neill Garber, Indianapolis, orthopedic, and Captain David E. Engle, Royal Center, cardiovascular service.

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# News Notes

Dr. A. J. Rissinger, formerly of Lake Forest, Illinois, is now a full-time associate of Dr. Don Cameron and Dr. Donald Creel at the Cameron Hospital in Angola.

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Dr. Paul B. Smith, who for many years has been located in East Chicago, limiting his practice to eye, ear, nose and throat work, has gone to Tacoma, Washington, where he has taken over the practice of Dr. Guy E. Griffith, recently retired.

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### CHEST PHYSICIANS CANCEL MEETING

The American College of Chest Physicians, with a membership in twenty-three countries, has cancelled its annual meeting which was scheduled to be held at Philadelphia in June. The Executive Council of the College will hold a business meeting of the Board of Regents, at Chicago, on June seventeenth.

### EIGHTH DISTRICT MEETING

On June thirteenth the Eighth District Medical Society will hold a meeting at the Winchester Country Club, at Winchester, at 6:00 P. M. This will be a dinner meeting with a program following.

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Dr. Richard J. Reynolds has opened an office in Salem for the practice of medicine. He is a graduate of the Indiana University School of Medicine, and recently completed his internship at the Indiana University Medical Center.

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Major Paul L. Long and Miss Helen Stahlsmith, both of Anderson, were married on February twenty-sixth at the home of Dr. and Mrs. Guy Ross, of Anderson. Major Long recently returned to this country following extensive duty with the Army Medical Corps in the Pacific, and had a twenty-one-day leave before reporting for reassignment.

Dr. J. D. Combs and Miss Fay Meshew, both of Muncie, were married at the home of the bride's brother in Lewisburg, Ohio, on March first. Until recently Mrs. Combs has been a supervisor at the Ball Memorial Hospital, where Doctor Combs recently completed his internship.

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Mr. Rollis Weesner has been named as the new executive secretary of the Lake County Medical Society, succeeding Mr. Rollen W. Waterson, who resigned recently to accept a similar position in California. Mr. Weesner has been connected with the Hammond school system for a number of years, and is well known over the county.

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Dr. R. G. Ikins, of Lafayette, has been released from the Army Medical Corps, where he held the rank of major, and has returned to private practice in Lafayette.

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### GENERAL MEETING OF SIXTH COUNCILOR DISTRICT CANCELLED

In keeping with the present ODT regulations, the Sixth Councilor District meeting to be held at Rushville on May tenth will not be a general meeting, and will be conducted as a business meeting, open only to the president and secretaries of each county society and the president and secretary of the Sixth Councilor District.

Dr. Marion F. Arnold, of New Palestine, and Miss Kathryn Costellow, of Beech Grove, were married March twenty-first in the Madonna Chapel of the Third Christian Church, in Indianapolis. Dr. Arnold is a graduate of the Indiana University School of Medicine, and is serving his internship at St. Catherine's Hospital in East Chicago.

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Dr. Louis H. Osterman, of Seymour, has opened new offices in a two-story residence at 315 West Second Street, in Seymour, which has recently been converted into suitable quarters for a physician's office. Doctor Osterman was formerly located at the Seymour Clinic.

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After having served nearly four years as captain with the Army Medical Corps, Dr. Floyd O. Rogers has been given a medical discharge, and has returned to Bloomington to resume his practice of medicine. He will again be associated with his uncle, Dr. Robert C. Rogers. During the time he was in service, Doctor Rogers was in the thick of the Pacific campaign, having seen service in some of the worst battles. He was at Guadalcanal, Leyte, New Georgia, and the Munda Air Field, as well as participated in other front-line and jungle fighting. While in the service Captain Rogers was elected to the Faculty of the American College of Surgeons.

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## INDIANA UNIVERSITY NEWS NOTES

Post-graduate meetings for Army medical personnel at Billings General Hospital, Fort Benjamin Harrison, and Wakeman General Hospital, Camp Atterbury, were held April 11th at each of the hospitals, under the direction of Dean W. D. Gatch, of the Indiana University School of Medicine, acting as Indiana chairman of wartime postgraduate courses given under the auspices of the American Medical Association, American College of Physicians, and American College of Surgeons. The Billings Hospital meeting had as its speaker, Captain Irving Speigel, of Mayo General Hospital, who discussed "Plexus and Peripheral Nerve Injuries." Speakers at the Wakeman Hospital meeting were Dr. Harold M. Trusler, chairman of the Division of Plastic Surgery, Indiana University School of Medicine, and Major Truman Blocker, of the Wakeman staff, on the subject of "Burns and Plastic Surgery."

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The annual Anatomical and Clinical Course in Otorhinolaryngology conducted by the Indiana University School of Medicine, was held April 16 inclusive of 28. Originated twenty-six years ago, by the late Dr. John F. Barnhill, the course, now under the direction of Drs. E. N. Kime and C. H. McCaskey, is the only postgraduate course being given by the Indiana University School of Medicine during the war. Primarily an intensive course in anatomy of the head and neck, it goes into the detailed study of this region.

Correlated subjects of otolaryngology were studied, supplemented by important discussions and surgical and dry clinics. The Indiana University course is believed to be the only one offered by a medical school in which the clinical application is correlated with the anatomical study. Histopathology, under the guidance of Dr. Clyde G. Culberton, was allotted additional time during this year's course, and an added feature was the study of a set of Army medical museum slides.

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Indiana University School of Medicine graduates have accepted internships in the following hospitals:

City Hospital, Indianapolis: Joseph M. Black, Seymour; Robert G. Claeys, Mishawaka; Edward T. Edwards, Jr., Bloomington; Arthur H. Girod, Decatur; Richard S. Griffith, Greenfield; Alvin L. Henry, Seymour; Howard J. Henry, Knox; Walter H. Hollis, Princeton; Rex L. Huff, South Bend; James F. Johnson, Indianapolis; William A. Koontz, Roanoke; Robert J. Lehman, Berne; Frank H. Miller, Rushville; Robert E. Moses, Worthington; Ernest C. Murray, West Lafayette; Harold W. Shonk, Rochester; and Gerald M. Wohlfeld, Indianapolis.

Methodist Hospital, Indianapolis: Frank B. Adney, Jr., Lebanon; James L. Borders, Indianapolis; John E. Lynch, Lafayette; Wilbert McIntosh, Terre Haute; John E. Mackey, Evansville; Floyd W. Mohler, Markle; William R. Noe, Seymour; Robert D. Pickett, Sheridan; John S. Scott, Richmond; Edward J. Szaulewicz, South Bend; Richard L. Veach, Bainbridge; Lewis H. Walker, Indianapolis; and Irvin L. Zeiger, Mishawaka.

Indiana University Hospitals, Indianapolis: Melvin A. Block, Evansville; Joseph E. Coleman, Indianapolis; Hadley L. Conn, Jr., Danville; Carl W. Goebel, Fort Wayne; John P. Graf, Indianapolis; Morris Green, Indianapolis; Charles Y. Knowles, Indianapolis; Beaufort A. Spencer, Muncie; and Stanley Zelman, Indianapolis.

St. Vincent's Hospital, Indianapolis: William G. Clevinger, Brookston; Charles I. Fisch, Indianapolis; Carl L. Green, Vincennes; John R. Moriarty, Indianapolis; and Geraldine M. Zix, Indianapolis.

St. Margaret's Hospital, Hammond: Raymond A. Abraham, Evansville; and Paul M. Dassel, Evansville.

Epworth Hospital, South Bend: Robert T. Allen, Richmond; William L. Bridges, Knightstown; Richard N. Land, Richmond; and Ralph C. Singer, Indianapolis.

Ball Memorial Hospital, Muncie: Forrest J. Babb, Jr., Bedford; Ray Morford, Bicknell; Mort H. Moseley, Pellville, Kentucky; Willard A. Scantland, Richmond; and Don A. Sears, Odon.

St. Mary's Mercy Hospital, Gary: William L. McDaniel, Indianapolis; and Harlan B. Moss, Centerpoint.

St. Elizabeth's Hospital, Lafayette: Charles G. Smith, Indianapolis; John R. Van Kirk, Kentland; and Richard H. Shafer, Alexandria.

Methodist Hospital, Gary: Leo M. Smith, Portland; and Adolph P. Walker, Mishawaka.

Others are Bernard S. Abrams, Cleveland, Ohio, St. Louis City Hospital; Justin E. Arata, Mishawaka, United States Naval Hospital, Oakland City, California; John W. Beeler, Indianapolis, Philadelphia General Hospital; Roger P. Bissonnette, Wolcott, William Seymour General Hospital, Eloise, Michigan; I. Alfred Breckler, Fort Wayne, Kings County Hospital, Brooklyn, New York; George D. Buckner, Fort Wayne, Grace Hospital, Detroit, Michigan; Thomas D. Carpenter, Naval Hospital, Shoemaker, California; James R. Cook, Hammond, Philadelphia General Hospital; Howard T. Craven, Staten Island Hospital, Staten Island, New York; Ray O. Creager, William J. Seymour Hospital, Eloise, Michigan; Richard C. Datzman, Otterbein, St. Mary's Hospital, Detroit; Harry D. Ellis, Queens Hospital, Honolulu, Hawaii; Frederick C. Green, Fort Wayne, Harlem Hospital, New York; Francis G. Henderson, Wisconsin General Hospital, Madison, Wisconsin; Stanley H. Hoffman, St. Louis City Hospital; Frank D. Hogle, United States Naval Hospital, Long Beach, California; Jack H. Horton, Marion, Denver General Hospital, Denver, Colorado; George S. Hughes, Indianapolis, Stanford Hospital, Stanford, Connecticut; Richard M. Johnston, Fort Wayne, Grace Hospital, Detroit, Michigan; Clifford H. Jope, Jr., Indianapolis, Southern Pacific General Hospital, San Francisco; Omar A. Kenyon, Jr., St. Francis Hospital, Peoria, Illinois; John E. Krueger, Michigan City, William J. Seymour General Hospital, Eloise, Michigan; Alexander T. Lebamoff, Fort Wayne, St. Mary's Hospital, Detroit, Michigan; Raleigh E. Lingeman, Indianapolis, Rochester General Hospital, Rochester, New York; James G. Lorman, Connersville, Grace Hospital, Detroit, Michigan; Gordon C. McLaughlin, Terre Haute, Denver (Colorado) General Hospital; Robert W. Osborne, Windfall, St. Louis General Hospital; Harry B. Overesch, Jr., William J. Seymour Hospital, Eloise, Michigan; Paul E. Parker, Jr., Marion, United States Public Health Service; Joseph L. Pedicini, St. Michael's Hospital, Newark, New Jersey; John F. Phillips, Butlerville, Lancaster (Pennsylvania) General Hospital; Robert M. Raber, Indianapolis, United States Naval Hospital, Oakland, California; Edgar A. Rado, Indianapolis, United States Public Health; William L. Ridgway, Evansville, Cook County Hospital, Chicago; Daniel Schlesinger, Hammond, Cook County Hospital, Chicago; Walton W. Shreeve, Muncie, United States Naval Hospital; Richard A. Silver, Knightstown, Rochester (New York) General Hospital; Gaylord W. Stalter, Fort Wayne, Binghamton (New York) City Hospital; Robert L. Stewart, Sullivan, Gorgas Memorial Hospital, Ancon, Panama; Francis E. Stout, Muncie, Grace Hospital, Detroit, Michigan; Homer R. Swihart, Elkhart, Harris Memorial Methodist Hospital, Fort Worth, Texas; Pierre C. Talbert, Auburn, Stamford (Connecticut) Hospital; Donald L. Trinosky, LaCrosse, St. Mary's Hospital, Detroit, Michigan; Robert W. Turgi, New Castle, Cook County Hospital, Chicago; Walter J. Van Sickle, Indianapolis, Thomas D. Dee Memorial Hospital, Ogden, Utah; John S. Visher, Evansville, Philadelphia General Hospital; Norbert M. Welch, Indianapolis, St. Joseph's General Hospital, San Francisco, California; William M. Wiley, Shelbyville, Eloise General Hospital, Eloise, Michigan.

# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION

### EXECUTIVE COMMITTEE

January 20, 1945

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; N. K. Foster, M.D.; F. T. Romberger, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney, and T. A. Hendricks, executive secretary.

Guests: Morris Crain, state agent, St. Paul Mercury Indemnity Company, Indianapolis; Don C. Hawkins, special agent, American Health Insurance Corporation, Chicago; Norman M. Beatty, M.D., co-chairman, Legislative Committee; Herman M. Baker, M.D., past president, Indiana State Medical Association, and member of the State Board of Health; Larue D. Carter, M.D., chairman, and C. L. Williams, M.D., and G. E. Metcalfe, members of the Committee on Mental Health.

**Membership Report:**

| | |
|---|---|
| Number of members Jan. 20, 1945 | 1210 |
| Number of members Jan. 20, 1944 | 1910 |
| Loss over last year | 700 |
| Number of members Dec. 31, 1944 | 3396 |

Statements of receipts and expenditures for December for the association committees and THE JOURNAL were approved.

**Treasurer's Office**

Audit by George S. Olive and Company reviewed by the committee.

**1944 Annual Session, Indianapolis**

Report received from Dr. Bert Ellis, chairman of the Convention Arrangements Committee, showing balance of $193.72 left of the amount allowed by the Council for entertainment purposes. The committee moved that a letter be written to Dr. Ellis, thanking him and the members of his committee for the fine job they had done upon the convention.

**1945 Annual Session, French Lick, Tuesday, Wednesday, and Thursday, October 2, 3, and 4, 1945**

ODT ruling in regard to conventions brought to the attention of the committee. The committee felt that for the present it would not cancel the meeting,

*(Continued on page xxix)*

*(Continued from page 172)*

but would wait for developments. By May first a definite ruling in regard to holding such meetings may be made.

*Commercial exhibit.* Forty-four spaces were sold to forty-one exhibitors.

Report upon 1945 facilities ready for consideration of the Council.

The committee was to keep in mind having some other group cooperate with the state medical association in carrying on the 1945 annual meeting.

**Legislative, Legal, and Social Security Matters**

*National*

The Pepper Interim Report brought to the attention of the committee.

Report made upon Washington meeting with Vice-President Truman.

Bulletins from the Washington office of the new Public Relations Council distributed to members of the committee.

*Local*

*Legislative session.* Dr. Beatty made a report upon legislation that is before or likely to come before the Legislature.

a. *Association bills.* The state medical association is sponsoring two bills, *H. B. 129* and *H. B. 143*, the first to allow physicians to be members of hospital boards, and the second to re-organize and modernize the State Board of Medical Registration and Examination.

b. *Fourteen-point public health program.* This program has been approved in principle by the House of Delegates of the Indiana State Medical Association, but the specific bills themselves have yet to receive approval. Copies of these are to be obtained as soon as they are ready and are to be sent to all local legislative committeemen.

c. *Mental hospital clinic bill.* The Executive Committee authorized the Legislative Committee and the Mental Health Committee to get together to formulate this program and to work out details of the bill. Dr. Carter's committee withdrew to discuss and work out details of this measure. The Executive Committee approved the project with the proviso that it met the approval of the Mental Health and Legislative committees. Complaints in regard to the establishment of such a center forwarded to the Mental Health Committee.

d. *Hospital Council bill, H. B. 390.* This bill has the backing of the Indiana Hospital Association. The Legislative Committee was instructed to see that copies of this bill are made and distributed to the county legislative committeemen for their consideration.

e. *Osteopathic bill.* Dr. Beatty reported that the osteopaths are to present a bill to the Legislature *(H. B. 176)*. The Executive Committee instructed the Legislative Committee to present this bill to the Council for any action the Council believes should be taken in this matter.

f. *Cult bills.* A naturopathic bill and a chiropractic bill are to be introduced. (These were intro-


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GYNECOLOGY—Two Weeks Intensive Course June 18. One Week Personal Course Vaginal Approach to Pelvic Surgery May 21 and July 9.

OBSTETRICS—Two Weeks Intensive Course June 4.

ANESTHESIA—Two Weeks Course Regional, Intravenous and Caudal Anesthesia.

ROENTGENOLOGY—Courses in X-ray Interpretation, Fluoroscopy, Deep X-ray Therapy every week.

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duced on February 2; *S. B. 181*, the chiropractic bill, and *S. B. 193*, the naturopathic bill.)

g. Other bills discussed, upon which the committee decided to take action neither for nor against were the northern Indiana hospital for crippled children measure and the enrichment of white flour bill.

**Prepayment Medical Plans**

Dr. Forster presented names of members to be appointed on the Committee on Prepayment of Medical and Surgical Care. This is a committee of twenty-one members.

Suggestion received from Minnesota that Indiana, Ohio, and Minnesota, and any other states, go together and work out a plan. This was referred to Dr. W. U. Kennedy, chairman of the Committee on Prepayment of Medical and Surgical Care.

*American Health Insurance Corporation.* Don C. Hawkins, special agent, discussed the American Health Insurance Corporation plan with the committee. It was suggested that he get in touch with Dr. W. U. Kennedy, chairman of the Committee on Prepayment of Medical and Surgical Care.

The names of Dr. J. T. Oliphant and Dr. A. F. Weyerbacher were suggested for membership on the Blue Cross Hospital Board, to serve with Dr. Bruce Stocking and Dr. Wemple Dodds as members of the Indiana State Medical Association on that board.

A sample contract of the New York City United Medical Service was brought to the attention of the committee.

**Organization Matters**

AAPS letter from Lake County brought to the attention of the committee.

Letters from Warrick, Miami, Switzerland, and Howard counties in regard to raise in dues, and answers to these letters, brought to the attention and approved by the committee.

Study made by Dr. Will Thompson, of Liberty, in regard to the geographical distribution of presidents of the Indiana State Medical Association brought to the attention of the committee. The committee expressed its appreciation of this study made by Dr. Thompson and suggested that it be sent to Dr. E. M. Shanklin, editor of THE JOURNAL.

Letter received from Dr. Oliphant, retiring president, expressing his deep appreciation to the committee, read to the committee. The members of the committee passed a motion, thanking Dr. Oliphant and sending him their best wishes.

**Medical Economics**

The Executive Committee was informed that the Indiana State Medical Association is now a member of the Indiana State Chamber of Commerce.

Letter received from Dr. F. S. Crockett in regard to the Midwestern Agricultural Workers' Health Association, Inc., brought to the attention of the committee.

Correspondence in regard coroners' investigations, including opinion of Albert Stump, brought to the attention of the committee.

**War and Postwar Medicine**

The committee authorized the officers of the association to do everything possible to aid in the recruitment of nurses for the armed forces.

Numerous letters from doctors in service, expressing complaints, brought to the attention of the committee. These were forwarded to Dr. Bird for consideration.

The committee authorized a complete investigation made of the report that an Indiana veteran had been enrolled in a cult school and is receiving federal funds, at least in part payment for his education at that school. Such practice, following the last war, resulted in the tremendous growth and expansion of the Palmer School of Chiropractic. Preliminary investigation revealed that the list of accredited schools which may accept ex-service men for training with federal funds is compiled not in Washington but in each state by the State Department of Public Instruction. A list of these schools accredited by the Indiana State Department of Public Instruction contains no cult schools.

**Socialized Medicine**

Publication of "Medical Care" by Michael Davis will be discontinued.

Information received that a survey among the medical profession in Michigan revealed that a certain number of physicians there are considering favorably the suggestion that they unionize.

A list of government-designated physicians for 1939 was brought to the attention of the committee. It was felt that nothing could or should be done in this matter until up-to-date information could be obtained.

**Cult Practice**

Further correspondence in regard to the one dollar physical examination clinic brought to the attention of the committee, along with a letter in regard to the Universal Society of Pathometrists, stating that this group would not hold a convention in Indianapolis as long as groups in Indiana were so opposed to them.

**Future Meetings**

January 21, 1945—Midwinter Council meeting and Secretaries' Conference.

The Congress on Medical Service, the National Conference on Medical Service, and the Congress on Industrial Health, which were to be held in February, and the American Medical Association meeting, to be held in Philadelphia in June, have been canceled. The American Medical Association, however, has filed an application to have a meeting of the House of Delegates.

**The Journal**

*Paper Situation.* The number of pages used in THE JOURNAL during 1945 will be governed by the paper quota.

The committee approved an increase in the advertising rates, which, however, constitutes only a partial increase in revenue because of the fifteen

"SINCE many of the conditions obtaining among troops during war time are simultaneously factors which predispose to the endemic and epidemic spread of . . . amebic dysentery among military personnel and civilians . . . these diseases assume great significance . . . not only to the medical departments of the armed forces but to the civilian physician as well." —Lt. Com. W. L. Voegtlin, USNR: N.W. Med., 43:69 (1944)

Increased investigation into "tropical diseases" has disclosed the unsuspected prevalence of amebic dysentery in the United States.

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*Silverman, D. N.; Amer. J. Digest. Dis. & Nut., 4:281-282 (July) 1937.

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

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RESEARCH IN THE SERVICE OF MEDICINE

per cent agency commission and the two per cent discount recently adopted by the Cooperative Medical Advertising Bureau.

The committee approved a five dollar per year JOURNAL subscription fee to all non-members of the association.

*Clinical Medicine* has asked for the right to reprint an article written by Dr. A. P. Hauss, entitled, "The Home Guard." The committee left this to Dr. Hauss' discretion.

*Membership Roster.* Letter received from Floyd Boys, M.D., asking that a special designation be given in the membership roster to men discharged from service. The committee felt that this roster should remain as it is.

*Cancellation of Lederle Advertising.* The committee was informed that Lederle Laboratories had canceled all 1945 advertising in journals represented by the Cooperative Medical Advertising Bureau.

*Seventh War Loan.* The committee approved the request of the National Publishers Association that the cover for the June issue of THE JOURNAL be reserved for the Seventh War Loan.

*Cooperative Advertising Bureau.* Check from the Cooperative Medical Advertising Bureau representing THE JOURNAL'S commission for 1944 received.

### Medical Defense

*Group Insurance in Lake County.* The Lake County situation in regard to group malpractice insurance was discussed by Dr. Forster, Morris Crain, local agent, and Don Hawkins of the St. Paul Mercury Indemnity Company. All efforts are to be made to straighten out this situation.

There being no further business, the meeting was adjourned.

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## LOCAL SOCIETY REPORTS

**CASS COUNTY MEDICAL SOCIETY** members held a dinner meeting with the members of the Women's Auxiliary, at the Cass County Hospital, on March sixteenth. The speaker at this meeting was Dr. William V. Woods, of Indianapolis. Approximately twenty members and guests were present.

**DELAWARE-BLACKFORD COUNTY MEDICAL SOCIETY** members met at Hotel Roberts, in Muncie, on March twentieth, for the transaction of current business. Twenty-eight members attended the meeting.

**ELKHART COUNTY MEDICAL SOCIETY** members met at Hotel Elkhart, on April fifth, for an Industrial Health meeting. The guest speakers were Senator Paul Kerr, whose subject was, "Recent Legislative Assembly Accomplishments," and Dr. Louis W. Spolyar, of Indianapolis, who discussed "Problems in Industrial Health." Twenty-nine members and guests were present at the meeting.

**VANDERBURGH COUNTY MEDICAL SOCIETY** members met at Hotel McCurdy, in Evansville, on March thirteenth, to hear Dr. Frank McDowell, of Washington University, St. Louis, whose subject was "Plastic Repair following Burns." The forty-eight members present also saw a moving picture on "Fixation of Jaw Fractures."

**INDIANAPOLIS (MARION COUNTY) MEDICAL SOCIETY** members met on April third, at the Indianapolis Athletic Club. The program consisted of case reports presented by Drs. Ross E. Griffith, Arthur B. Richter, Clark W. Day, and Carl Habich, all of Indianapolis.

On April tenth, "Lesions of the Tongue," was presented by Dr. Russell A. Sage, of Indianapolis, and "Disorders of the Female Endocrine System," was presented by Dr. Don Carlos Hines, and discussed by Dr. Carl P. Huber.

On April seventeenth the program was presented by the City Hospital Staff and was held at the City Hospital auditorium. "Head Pain," was presented by Dr. Mortimer Mann, and discussed by Drs. E. Vernon Hahn and David E. Brown. "New Method of Hip Nailing" was presented by Dr. S. W. Campbell, and discussed by Drs. Frank W. Teague and E. Bishop Mumford. "Use of Digitalis in Children" was discussed by Drs. J. DeFries, G. F. Kempf, and Lyman T. Meiks.

At another meeting on April twenty-fourth, Dr. Edith L. Potter, of the University of Chicago, spoke on "Present Status of the Rh. Factor."

**ST. JOSEPH COUNTY MEDICAL SOCIETY** members met in the Bronzewood Room of Hotel LaSalle, at South Bend, on March twenty-eighth. The speakers at this meeting were Dr. Frederic A. Gibbs, of Boston, who read a paper on "Electroencephalography in Practice"; Dr. L. J. Meduna, of Chicago, who presented "Clinical Indications for Shock Therapy" and Dr. Warren S. McCulloch, also of Chicago, whose subject was "Brain Physiology in Convulsions." Eighty-five members and guests attended the meeting.

**HOWARD COUNTY MEDICAL SOCIETY** members had Dr. Thurman B. Rice, of Indianapolis, as their guest speaker at a meeting held at the St. Joseph Memorial Hospital, in Kokomo, on March second. Dr. Rice's subject was "Undulant Fever." A number of veterinarians were present as guests of the society, and participated in the general discussion which followed the talk.

At another meeting on April sixth, the speaker was Dr. Edward T. Stahl, of Lafayette, who discussed "Treatment of Fractures," illustrated with lantern slides and x-ray plates. Fifteen members were present.

**WABASH COUNTY MEDICAL SOCIETY** members met at the Womens' Club, in Wabash, on March seventh. The program consisted of a motion picture entitled "Nutrition."

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### CONFERENCE ON INDUSTRIAL HEALTH

Following are the minutes of the meeting of the Committee on Industrial Health, of the Indiana State Medical Association, held January 21, 1945: Members present—Jones, Weller, Doty, Yarrington, Spolyar, and one physician from Lafayette—name not recorded.

1. All agreed that the Annual Conference on Industrial Health should not be held this year due to the ruling by OCD. Dr. Jones had a wire from Byrnes stating that this meeting should not be held. In lieu of this meeting, it was decided that every district should plan a program on industrial medicine for the coming year. A list of speakers will be furnished the districts by this committee. These speakers may be used if the district desires to do so.

A letter is to be sent to all Indiana physicians, informing them that the conference will not be held. A notice to that effect will also be placed in THE JOURNAL.

2. Each member of the committee is to receive a copy of the *Lake County Code of Ethics.* This material is to to be reviewed and sent to Dr. Jones for assembly, and then reintroduced for consideration by the medical association.

3. Plans were formulated as to how industrial physicians might secure data relative to the reason for a medical discharge of a veteran. The committee is to work through the Veterans Administration.

## *WOMAN'S AUXILIARY to the Indiana State Medical Association*

**President—Mrs. F. M. Gastineau, Indianapolis**
**President-elect—Mrs. S. J. Petronella, East Chicago**
**Corresponding Secretary—Mrs. C. L. Bock, Indianapolis**
**Treasurer—Mrs. A. W. Ratcliffe, Evansville**
**Press and Publicity—Mrs. A. B. Richter, Indianapolis**

### ALLEN COUNTY

The program committee of the Allen County Medical Auxiliary entertained with a dinner party on March sixth, at the Chamber of Commerce. Honored guests were Major and Mrs. Frank Neff and Captain and Mrs. C. F. Bassow. Captain Bassow, who recently returned after sixteen months of service in the Southwest Pacific, addressed the group on "Tropical Medicine."

Mrs. N. L. Salon recently entertained approximately fifty members of the Allen County Medical Auxiliary in her home. Dr. Grace Rabson, the guest speaker, presented an interesting talk on "Europe's Effect on Early American Music."

### CASS COUNTY

Ten members of the Cass County Medical Auxiliary met with the Cass County Medical Society at a dinner meeting, March sixteenth, at the Cass County Hospital. Mrs. Ed Lybrook, the president, presided. Routine business was conducted, and a report was given by Mrs. Harry Shultz on the number of hours of Red Cross work completed. Plans were made to entertain the wives of the doctors who will attend the district medical meeting on May sixteenth.

### FLOYD COUNTY

The Woman's Auxiliary to the Floyd County Medical Society met on February sixteenth at the home of Mrs. C. E. Briscoe, of New Albany. Miss Lucretia Saunders, public health educator, spoke on public health work and post-war planning. Eleven members were present.

### MADISON COUNTY

Mrs. L. Overpeck, of Alexandria, reviewed Emily Kimbrough's book "How Dear to My Heart," at the February nineteenth meeting of the Madison County Auxiliary.

### VANDERBURGH COUNTY

Dr. Morris Fishbein spoke on March twenty-third at the Trinity Methodist Church in Evansville. His topic was "Medicine in the Postwar World." This meeting was sponsored by the Vanderburgh County Auxiliary, and was open to the general public.

### VIGO COUNTY

The Woman's Auxiliary to the Vigo County Medical Society held its March meeting at 2:00 P.M. on March twelfth, in the auditorium of the Union Hospital at Terre Haute. Dr. Alfred R. Stanley, of the Commercial Solvents Corporation, was the speaker. His subject was "Penicillin." This meeting was open to the public, and many interested persons attended.

---

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*Welch, Henry, and Hunter, Albert C., Method for Determining the Effect of Chemical Antisepsis on Phagocytosis, Am. Jnl. of Public Health, Vol. 30, No. 2, Feb. 1940.

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# THE JOURNAL

OF THE

# INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

*ISSUED MONTHLY under Direction of the Council*

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 38 JUNE, 1945 Number 6

## USES OF PENICILLIN IN OTOLARYNGOLOGY*

MAJOR DILLON D. GEIGER, M.C.†

KEESLER FIELD, MISSISSIPPI

Seldom has a new therapeutic agent excited as much interest as has penicillin, a potent chemotherapeutic agent obtained from a common mold, Penicillium notatum. Penicillin has opened a new era in medical therapeutics, since it is a chemotherapeutic agent which is almost completely innocuous to the human host and yet highly effective against specific invading micro-organisms responsible for infection. Penicillin has been found to be of value in the treatment of acute conditions of the ear, nose, and throat, and in combination with adequate surgical treatment offers a most effective means of combating some of the serious and life-endangering infections and complications of otolaryngology. The drug will bring about prompt improvement in acute infections, and in some cases it produces spectacular results; but it must be emphasized that penicillin is an extremely valuable adjunct to ear, nose, and throat surgery, and not a substitute for it. Its use does not lessen the importance of fundamental surgical principles, but makes possible the application of these principles in a much wider field and permits certain procedures to be performed earlier and more safely than otherwise would be possible.

Most authorities are agreed that the action of penicillin is essentially bacteriostatic, with a marked degree of specificity. It may, however, under ideal conditions be bactericidal. Penicillin is not a protoplasmic poison, does not combine with the organisms or tissue cells, does not affect leukocytes, but accomplishes its antibacterial influence by affecting the functional activity of certain micro-organisms. It induces morphologic changes in these organisms accomplished by interference with the normal biologic processes, and appears to have a primary inhibitory effect upon the reproduction of susceptible organisms. The multiplication of these organisms is impeded and cell division interfered with, and a bacteriostasis rather than lysis results. Penicillin prevents bacteria from dividing and multiplying; does not kill bacteria, but makes them easy for the body defenses to kill. The action of penicillin is not interfered with by the number of bacteria present, bacterial extracts, pus fluids, tissue autolysates, or peptone, nor does the presence of organic material impair the ability of penicillin to inactivate sensitive organisms. The inhibitory properties of penicillin are neutralized, however, by substances contained in certain organisms, notably the colon bacillus group.

The bacterial activity of penicillin, though selective, covers a wide range of organisms, the limitations of which are not as yet determined. The greatest efficacy is manifested against the aerobic and anaerobic gram positive bacteria. Against gram negative organisms penicillin generally exerts little or no effect, and it is of special interest, therefore, that the gonococcus, the meningococcus, and Micrococcus catarrhalis, gram negative diplococci, are among the organisms most sensitive to penicillin.

The absorption and excretion of penicillin are dependent upon the mode of administration, the dosage, and the status of the kidneys. Absorption is very rapid, and when penicillin is administered intravenously the concentration in the plasma rises promptly, reaching its maximum immediately after the injection is completed, but falls rapidly. Peni-

* Presented before the Section on Ophthalmology and Otolaryngology, of the Indiana State Medical Association, at Indianapolis, October 4, 1944.

† Major Geiger was stationed at the Regional Station Hospital, Keesler Field, Mississippi, at the time this paper was presented, but has since returned to Bloomington, Indiana.

TABLE I

| *Susceptible Strains* | *Insusceptible Strains* |
|---|---|
| **Pneumococcus | Hemophilus influenzae |
| **Streptococcus haemolyticus | Escherichia coli |
| *Staphylococcus | Bacillus typhosus |
| ***Meningococcus | Bacillus dysenteriae |
| ***Gonococcus | Bacillus proteus |
| *Streptococcus viridans | Bacillus paratyphosus A |
| Bacillus subtilis | Bacillus enteritidis |
| Clostridium welchii | Bacillus pyocyaneus |
| Vibrion septique | Bacillus fluorescens |
| Clostridium histolyticum | Bacillus prodigiosus |
| Bacillus sporogenes | Friedlander's bacillus |
| Bacillus oedematiens | Staphylococcus albus-1 strain |
| Bacillus sordellii | Micrococcus albus-1 strain |
| Lactobacillus | Monilia albicans |
| Cryptococcus hominis | Monilia kruzei |
| | Monilia candida |

cillin is so rapidly excreted following intravenous or intramuscular injection that it must be administered continuously or at frequent intervals if constant plasma level and optimal therapeutic results are to be obtained. With intramuscular injection the drug is absorbed more slowly, peak concentration in the blood is slower, but a more sustained plasma level is obtained. The intramuscular route of administration shows a distinct advantage because the penicillin blood level remains at its peak for thirty to forty-five minutes, and the decrease is much more gradual than after the intravenous route. After intravenous or intramuscular administration, therapeutically effective amounts of penicillin do not reach the cerebrospinal fluid, joints, bursae, pleural cavities, mastoid spaces, sinus tracts, or large abscesses, and it is not found in saliva or tears. When injected directly into such spaces absorption is relatively slow and excretion is much retarded. If given orally penicillin is rapidly inactivated in the stomach by the hydrochloric acid of the gastric juice, and is of no effect. Rectal administration is not effective because it is largely neutralized by the bacterial enzymes of the lower bowel.

For therapeutic purposes, penicillin is administered intravenously, intramuscularly, locally, and intrathecally. Intravenously, penicillin may be given by continuous drip, dissolved in physiological salt solution, or in 5 per cent dextrose solution with a concentration ranging from 25 to 50 units per cc.; or by multiple intravenous injection in a concentration of 1,000 units per cc. For intramuscular administration the concentration of the drug should be 5,000 units per cc. For local application, penicillin in concentrations varying from 250 to 500 units per cc. of normal salt solution should be applied directly to the infected surfaces and kept continuously in contact with the area until the causative organisms are destroyed. The British use, for local application, weighed amounts of dried penicillin ground with sulfanilamide in a mortar to make a homogeneous mixture which may contain as much as 5,000 units per gram, and a cream containing lannette wax and penicillin, 100 to 250 units per gram. Penicillin is given intrathecally in a concentration of 1,000 units per cc. of normal salt solution, 10,000 units once daily.

The dosage of penicillin varies according to the sensitivity of the causative organisms, the nature of the infections, and the duration and severity of the disease. Strains of gonococcus and meningococcus were most sensitive to penicillin, and in decreasing order of sensitivity are pneumococcus, hemolytic streptococcus, Staphylococcus aureus, Streptococcus viridans, Staphylococcus albus, and the gram positive rods. In many serious infections recovery has followed administration of 40,000 to 50,000 units a day, while in others 100,000 to 120,000 units, or even more, are necessary. The staphylococci as a group require two to four times as much pencillin as do the streptococci, the usual case requiring 25,000 units intramuscularly, every three hours, or 200,000 units daily. The average person requiring intravenous or intramuscular injection for serious staphylococcic infection requires a total of between 500,000 and 1,000,000 Oxford units, and the best results have been observed when treatment is continued for at least ten days to two weeks. Infections caused by susceptible strains of streptococci require 90,000 units in the twenty-four-hour period, given intramuscularly in 15,000 unit doses every three hours, or intravenously in 7,500 unit doses every two hours. The major effect of therapy will be obtained in the first few days of treatment, and if response is not noted during the first four to five days dramatic effects are not probable thereafter.

No serious intoxication has occurred in man following the use of purified penicillin, although in clinical trials some transient toxic manifestations did occur occasionally. It is concluded that these were due to toxic impurities, and recent lots of penicillin have not caused similar reactions. Urticaria, as wheals widely distributed over the body, may occur as a complication and continue three to five days, and a few patients will develop a low-grade fever during the first three to five days of treatment. Thrombophlebitis at the site of continuous injection occurs frequently, noticeable during the second day, and may lead to chills and fever if therapy is continued through the same vein. This complication can be avoided by using dilute solu-

TABLE II

| *Indications for Penicillin in Otolaryngology* |
|---|
| 1. Acute tonsillitis. |
| 2. Peritonsillar abscess. |
| 3. Lateral pharyngeal abscess. |
| 4. Carbuncles and soft tissue abscess. |
| 5. Erysipelas. |
| 6. Cervical adenitis. |
| 7. Suppurative Parotitis. |
| 8. Cellulitis, floor of mouth. |
| 9. Ludwig's Angina. |
| 10. Acute sinusitis. |
| 11. Chronic sinusitis (not proved). |
| 12. Acute otitis media. |
| 13. Chronic otitis media. |

tions of penicillin and a daily change of position of the needle. Pain at the site of intramuscular injection is a frequent complaint and can be controlled by using ice packs for fifteen minutes before the injection.

Development of resistance to penicillin, although not common, occurred in some patients during treatment. Resistance is produced only after continuous exposure to the action of penicillin; therefore it is essential that treatment be started with full and adequate dosage and continued until satisfactory response results. Fortunately, resistance to penicillin is not accompanied by decreased sensitivity to sulfonamides, and the resistance to one apparently does not indicate resistance to the other. Small concentrations of sulfonamides, which alone are insufficient to affect the growth of either staphylococcus or streptococcus, very definitely increased the antibacterial influence of penicillin when added to the penicillin solutions. The combined use of penicillin and sulfonamides is advantageous.

In our clinic we isolate and identify the organism responsible for the infection by a bacteriologic and clinical investigation, and every effort is made to determine the infective agent before instituting treatment. Penicillin susceptibility is determined, but treatment is begun without waiting for the result. In cases of acute tonsillitis, peritonsillar abscesses, and lateral pharyngeal abscesses that we have treated with penicillin, the acute infection did subside promptly and the localized infections usually recover without incision; however, sound surgical principles should be applied and incision and drainage done when indicated. The response to treatment of Vincent's infection with penicillin has been so dramatic and the results so striking that there can be little doubt that penicillin is the most effective agent that has as yet been discovered in the treatment of this infection. Lesions of the mouth and tonsils heal rapidly, with disappearance of the organism after a few days of penicillin therapy by intramuscular injections.

Penicillin is of great value and even lifesaving in the treatment of extensive cellulitis of the floor of the mouth, Ludwig's, submaxillary space infections, and infections extending down the fascial planes of the neck. It is observed that diffuse and phlegmatic lesions responded more satisfactorily than localized infections, possibly because of the difference in the blood supply. Infections in well-vascularized soft tissue respond to much lower concentrations of penicillin than do relatively avascular hard tissues. The dramatic improvement offers promise that the drug will eliminate the need for extensive and radical surgery and reduce the frequency and severity of the complications which now so often arise in this type of infection. Herrell and Nichols reported sixteen cases of extensive cellulitis of the face of staphylococcic origin treated with penicillin, and with good results. They later reported six cases of extensive cellulitis of the floor of the mouth, two of which were complicated with bacteremia, and recovery resulted in all six cases.

In our cases of acute sinusitis, penicillin has been effective, with the best results obtained in acute maxillary sinusitis. Administration is by local application and intramuscular injection. We combine the use of the drug in acute sinusitis with bed rest, nasal shrinkage, and physiotherapy. Penicillin is given intramuscularly, 15,000 units q. 3. h., and after the first stages of the acute infections are over we irrigate the antrum with warm saline, either through the natural ostium or beneath the inferior turbinate. Following the irrigation we instill into the sinus four to ten cc. of penicillin solution containing 1,000 units per cc. We repeat the procedure daily, and usually in three to four days the antrum is clean. At first we allowed longer intervals between treatments, but now feel that by daily treatment we speed recovery and avoid recurrences. In a few cases of chronic maxillary sinusitis we have tried the same treatment with uncertain results. In some chronic, purulent, antral cases the cultures became sterile but the discharge continued, and at operation the membrane was thickened with chronic inflammatory changes present. Crow believes that in acute infections of the mucous membrane the bacteria grow on or near the surface, while in chronic infections they are deeply imbedded and inaccessible to local bacteri-

**TABLE III**

*Indications for Penicillin in Complications of Otolaryngology*

I. All staphylococcus infections with or without bacteremia.
   1. Acute osteomyelitis, (frontal and maxillary).
   2. Orbital cellulitis complicating paranasal sinus disease.
   3. Brain abscess.
   4. Cavernous sinus thrombosis.
   5. Acute labyrinthitis.
   6. Lateral sinus thrombosis.
   7. Meningitis.

II. All hemolytic streptococcus infections with bacteremia and all serious local streptococcus infections.
   1. Cellulitis.
   2. Ludwig's angina.
   3. Mastoiditis acute (locally).
   4. Mastoiditis with intracranial complications, i.e., meningitis, sinus thrombosis, et cetera.

**TABLE IV**

*Conditions Contraindicated to Penicillin*

Penicillin is contraindicated in the following cases because it is ineffective:
1. All gram negative bacillary infections:
   Typhoid—paratyphoid
   E. Coli
   H. influenza
   B. Proteus
2. Tuberculosis
3. Acute rheumatic fever
4. Lupus erythematosus, diffuse
5. Infectious mononucleosis
6. Pemphigus
7. Hodgkin's Disease
8. Acute and chronic leukemia
9. Poliomyelitis
10. Blastomycosis
11. Virus infections
12. Cancer

TABLE V

| *Administration and Dosage* |
|---|
| I. Intravenous, (5 per cent dextrose solution or physiological salt) |
| a. Continuous drip to deliver 2,000 to 5,000 O.U. per hour. Flow rate 30 to 40 drops per minute (2 liters per day). |
| b. Multiple injections, (1,000 O.U. per cc.) every three hours. Total dosage in twenty-four hours, 80,000 to 120,000 O.U. |
| II. Intramuscular, (5,000 O.U. per cc.) |
| a. Multiple injections, 5,000 O.U. every three hours. Total dosage 40,000 to 120,000 O.U. every twenty-four hours. |
| III. Intrathecal, (1,000 O.U. per cc.) |
| a. Inject 10,000 O.U. once daily. Total dosage 10,000 O.U. every twenty-four hours. |
| IV. Locally, |
| a. Physiological salt solution, 250 to 500 O.U. per cc. |
| b. Homogeneous mixture with sulfanilamide, 5,000 O.U. per gram. |
| c. Cream containing lanette wax 100 to 250 O.U. per gram. Continual contact with infected area until the causative organisms are destroyed. |

cides. This may explain the doubtful results in chronic cases.

We have no evidence to show that penicillin would be of value, topically, in the nose and throat; however, Bryson, Lansone, and Laskin studied the behavior of penicillin as an inhalant by using a solution of the sodium salt in a nebulizer, sprayed into the nose. They found that the drug passed through the respiratory system and was excreted in the urine, and it may prove to be of advantage as an aerosol in the treatment of respiratory infections. Also the effects of snuffs containing penicillin or sulfathiazole were tested in twenty persons who were nasal carriers of staphylococcus. The snuffs were administered six times daily, and from sixteen to thirty-two swabbings done on each person, the swabbings being cultured and examined for staphylococcus. Both penicillin and sulfathiazole appear to offer some promise of lessening the frequency of invasion of the nose with bacteria, or invasion of the nasopharynx through the nose.

The use of penicillin in the life-endangering complications of nasal sinus disease brought about spectacular improvement. There is every reason to believe that the prognosis in these cases will be greatly altered by this powerful bacteriostatic agent. The acute conditions have afforded the most gratifying results; while in chronic cases response is hard to evaluate. Osteomyelitis of the facial bones, one of the most serious complications of sinus disease, has been treated successfully with penicillin. If treated early and adequately in the acute stages the disease process may be stopped and healing take place without radical surgical measures. In such infections granulations have been made healthy, and draining, purulent wounds have become sterilized while the patients were receiving penicillin. Penicillin, in contrast to sulfonamides, prevents further spread of the infection. In cases which continue to show progressive bone destruction after adequate penicillin therapy, drainage by surgical intervention is necessary to effect a cure, and may be accomplished with little risk after the wound has become dry and the cultures have become negative. Surgical procedure is best postponed until the patient has had one to three weeks of penicillin therapy and sequestration has occurred, since there is then a better possibility of removing all the devitalized bone at one time. The optimum time for operative measures is during the period in which the infection has been checked by the penicillin, for relapses are likely to occur until all of the necrotic bone is removed. The postoperative course in such cases is less stormy when penicillin is given at least one week before operation and continued afterwards. In five cases reported by Kirby and Hepp the results would seem to justify the hope that the present high mortality rate in cases of acute and subacute osteomyelitis of the facial bones will be drastically reduced. Equally good results were reported by Putney in seven cases of osteomyelitis, five involving the frontal bone, one the frontal and maxillary bones, and one the superior maxilla. Brain abscess, extradural abscess, and orbital cellulitis occurred as complications in three cases of osteomyelitis without apparent bearing on the response to the drug. Putney also reports prompt and complete healing obtained in three cases of orbital cellulitis secondary to sinusitis,

TABLE VI

*OTOLARYNGOLOGY THERAPEUTIC REFERENCE TABLE*

| *Condition* | *Mode of Administration* | *Dosage* | *Duration and Collateral Therapy* |
|---|---|---|---|
| 1. Tonsillitis | Intramuscular | 15,000 O.U. q.3.h. | 1-3 days. |
| 2. Tonsillar abscess | Intramuscular | 15,000 O.U. q.3.h. | 2-5 days, surgery as indicated. |
| 3. Pharyngeal abscess | Intramuscular | 15,000 O.U. q.3.h. | 2-5 days, surgery as indicated. |
| 4. Vincent's infection | Intramuscular | 15,000 O.U. q.3.h. | 1-3 days. |
| 5. Furunculosis | Intramuscular | 15,000 O.U. q.3.h. | Until satisfactory response. |
| 6. Carbuncles | Intramuscular | 15,000 O.U. q.3.h. | Until satisfactory response, surgery is indicated. |
| 7. Erysipelas | Intramuscular | 15,000 O.U. q.3.h. | 2-5 days until response. |
| 8. Acute Cellulitis | Intramuscular or intravenous | 15,000 O.U. q.3.h. | 7 days or less, surgery is indicated. |
| 9. Acute sinusitis | Intramuscular, locally | 15,000 O.U. q.3.h. 5,000 | 3-5 days, local treatment is indicated. |
| 10. Otitis media | Intramuscular, locally | 15,000 O.U. q.3.h. 2,000 | Until satisfactory response. |

TABLE VII

*OTOLARYNGOLOGY THERAPEUTIC REFERENCE TABLE*
*All Staphylococcic Infections With and Without Bacteremia:*

| *Condition* | *Mode of Administration* | *Dosage* | *Duration and Collateral Therapy* |
|---|---|---|---|
| Acute osteomyelitis | Intramuscular or intravenous and local | 10,000 to 15,000 O.U. q.3.h. 250 to 500 O.U. per cc. NaCl solution | 1-2 weeks preoperative, 1 week postoperative; debridement and surgery as required. |
| Chronic osteomyelitis | Intramuscular or intravenous and local | 20,000 O.U. q.3.h. 250 to 500 O.U. per cc. NaCl solution | According to response; debridement and surgery as required. |
| Meningitis | Intrathecal | 10,000 O.U. once daily | 3-4 days; systemic measures as indicated. |
| Cavernous or lateral thrombosis | Intramuscular or intravenous | 15,000 to 20,000 O.U. q.3.h. | 7-10 days; supportive measures. |
| Orbital cellulitis | Intravenous or intramuscular | 5,000 O.U. q.3.h. | 3-5 days; surgery as indicated. |
| Brain abscess | Intravenous or intramuscular | 5,000 O.U. q.3.h. | 7-10 days; surgery as indicated. |

with vanishing of the pain within the first twelve hours of treatment. After the first day orbital edema, fixation, and proptosis began to decrease, but the underlying disease in the sinuses remained unaffected, and in two of the cases sinus surgery was necessary. In the other case during the early, acute stage of cellulitis, before pus formation, incision and drainage was not necessary. The infection resolved under treatment. All of these patients had previously received sulfonamide therapy with little improvement. We recently had two cases of orbital cellulitis which responded to penicillin without surgery.

Another complication of nasal sinus disease for which penicillin seems to be the ideal remedy is cavernous sinus thrombosis, because the Staphylococcus aureus is the infecting organism in the majority of these cases. An editorial in the *British Medical Journal*, of November, reviews eleven cases and concludes that penicillin is the drug of choice. Goodhill reports a case of bilateral cavernous sinus thrombosis in a five-year-old boy, with complete recovery when treated with penicillin, and after failure with sulfonamide-heparin therapy. The response to penicillin was dramatic and improvement began immediately after the first administration. Recently Nicholson and Anderson reported a case complicated by unilateral optic atrophy treated successfully.

Infectious diseases of the ear can be effectively treated with penicillin because the anatomic structure of the ear permits the local administration of the drug, and because the organisms causing most acute infections of the ear are in the group considered to be susceptible to the drug. According to Fowler's study of the causative organisms in 452 consecutive cases of acute otitis media, 90 per cent are susceptible to penicillin. The penicillin is administered intramuscularly and locally. The amount of the drug necessary to combat the infection will vary according to its causative organisms and severity.

In acute otitis media, if the drug is given early it may abort the infection; however, surgical indications for drainage of pus should not be neglected. In acute otitis media with a large perforation of the ear drum the duration of the discharge and the speed of closure of the perforation has been favorably influenced by the local instillation of penicillin solution into the ear canal, 2,500 units per cc. In special instances patients with chronic otitis media can be treated successfully by the local instillation of penicillin into the middle ear. The patient who has a chronic discharging ear caused by an organism susceptible to the drug, and has a large perforation of the ear drum, with no evidence of granulations or cholesteatoma, is best suited for penicillin therapy. Granulations or cholesteatoma contraindicate the use of penicillin. The pneumatic otoscope can be used to force the drug into the middle ear, and the penicillin can be sealed into the ear by means of cotton impregnated with a bland ointment. Swanson and Baker report two cases due to staphylococcus aureus treated successfully by this method, but several other cases did not respond satisfactorily. Penicillin has no effect on the perforation.

As a supplement to surgery when the drug is instilled into the mastoid cavity following operation, healing is prompt and the period of convalescence is shortened. The mastoid surgery is unorthodox. Free drainage is undesirable because the drug drains away with the exudate. It is best to establish a closed cavity into which penicillin can be instilled and from which exudate can be sucked away periodically if necessary. This may be accomplished by sewing up the wound from below, inserting a fine rubber tube with no side holes into the upper part of the wound down to the base of the cavity, and suturing it in place. After sufficient penicillin is injected to fill the cavity the tube is closed by a spigot. The suture line is smeared with a vaseline-penicillin mixture.

Florey and Florey employed the latter method in twenty-two cases of surgical mastoiditis, using controlled drainage. Penicillin was instilled into the cavity through the tube, which was then sealed off, 250-500 units per cc. Afterwards, every six hours,

the exudate was aspirated from the cavity through the tube, and fresh penicillin was instilled and the tube again sealed. Free drainage was not allowed at any time. This routine was employed for a period of five days, and an average of 17,300 units per case was required. The ear usually became dry within a period of five days and primary healing took place in nineteen of the twenty-two patients. Two failures occurred early in the series, and might be attributed to lack of experience with the method. No complications developed.

Two cases of acute mastoiditis have been treated with penicillin by Swanson and Baker. In one the intramuscular administration was begun four days before the operation and continued until the seventh postoperative day. Local treatment of the operative wound was carried out by means of the method of Florey and Florey, a solution containing 1,000 units per cc. being employed. The other patient received only local postoperative penicillin therapy, a solution containing 250 units per cc. being used. In both cases the causative organism was the streptococcus hemolyticus. In each, penicillin appeared substantially to shorten convalescence.

Penicillin has proved to be of definite value in the treatment of cases of septicemia due to thrombophlebitis of the lateral sinuses in mastoid diseases, and in the treatment of meningitis complicating otitic disease. Rosenberg and Arling recently reported three cases with hemolytic streptococcic meningitis, one with bacteremia, and one of a pneumococcic meningitis — all secondary to acute otitis media. Penicillin was administered both intrathecally and either intravenously or intramuscularly, and proved to be an effective, highly potent agent in the treatment of the meningitis; one to five intrathecal injections of 10,000 units each were used. Recovery resulted in all cases.

Penicillin, like any other chemotherapeutic drug, can mask the symptoms in the progress of an infection, and one must be alert to the possibility in order to avoid serious complications. Do not rely upon penicillin pre- or post-operatively in mastoiditis to prevent or control extension to the meninges or the brain. The drug does not reach the spinal fluid when given locally or parenterally. In postoperative mastoid surgery where any intracranial extension, present or future, is feared, give a sulfonamide drug in addition to penicillin. The sulfonamides do reach the spinal fluid. There is no contraindications to the simultaneous administration of penicillin and sulfonamides.

In conclusion, we believe penicillin, when confined to infections due to susceptible pathogens, is an effective agent in many of the acute ear, nose, and throat conditions; that its use will bring about prompt improvement, and in many cases spectacular results. It provides us with an effective means of combating serious and life-endangering infections and complications of otolaryngology; and the dramatic improvement following the use of the drug promises to reduce the need for extensive and radical surgery, and to reduce the frequency and severity of the complications. Penicillin is a valuable adjunct to ear, nose, and throat surgery, but is not a substitute for it; and the general principles and indications for surgical drainage remain unchanged.

## DISCUSSION

Lieutenant Colonel Gilbert C. Struble, Fort Benjamin Harrison, Indiana: Major Geiger has covered the history, method of action, and indications for penicillin therapy in otolaryngology very thoroughly. We are in substantial agreement with his findings. In brief, it may be said that given a penicillin sensitive organism as a cause for an infection of the ear, nose or throat, penicillin given early and in adequate dosage before suppuration has occurred, will probably abort and cure the disease. On the other hand, if suppuration has occurred and pus is present, the general surgical principles of drainage remain unchanged.

In the treatment of empyema of the maxillary sinuses, subacute or chronic, two factors are pres-

TABLE VIII

*OTOLARYNGOLOGY THERAPEUTIC REFERENCE TABLE*

*All Hemolytic Streptococcic Infections with Bacteremia and All Serious Local Infections:*

| *Condition* | *Mode of Administration* | *Dosage* | *Duration and Collateral Therapy* |
|---|---|---|---|
| Cellulitis | Intramuscular or intravenous | 10,000 O.U. q.3.h. | 4-5 days. |
| Ludwig's angina | Intramuscular or intravenous | 10,000 O.U. q.3.h. | 4-5 days, surgery as indicated, supportive measure |
| Mastoiditis | Local | 250-500 O.U. per cc. NaCl solution q.6.h. | 5-7 days. |
| Mastoiditis with intracranial complications, (meningitis, sinus thrombosis, et cetera) | Local and intrathecal | 250-500 O.U. per cc. NaCl solution q.6.h. | 4-5 days. |
| ALL PNEUMOCOCCIC INFECTIONS: | | | |
| Meningitis | Intrathecal | 10,000 O.U. once daily | 2-3 days; systemic therapy. Local treatment to focus of infection. |
| ALL MENINGOCOCCIC INFECTIONS: | | | |
| Meningitis | Intramuscular or intravenous and intrathecal | 10,000 O.U. once daily | 2-4 days. |

ent to explain the excellent results of penicillin treatment by instillation. First, surgical drainage is obtained by irrigation. Second, very high concentrations of penicillin can be brought into contact with the infected site. Penicillin therapy used by displacement, in chronic suppurative diseases of the ethmoid and sphenoid, acts in a similar manner. For the displacement therapy we have used ⅛ per cent ephedrine in normal saline containing penicillin 1 cc. = 200 units.

In acute middle ear disease, myringotomy and mastoidectomy are still indicated if suppuration or cell breakdown is present. It is well to remember that penicillin can mask symptoms the same as the sulfonamide drugs. Penicillin by parenteral injection should not be relied upon to prevent or control extension of the infection to the brain or meninges either before or after surgery. In such cases, when indicated surgical procedures have been carried out, sulfonamide therapy should be combined with the use of penicillin. In the simultaneous administration of both penicillin and sulfonamide therapy, it appears clinically that one enhances the effect of the other. For a time we used penicillin solutions in the mastoid wound as a postoperative measure with good results. We have found, however, that the instillation of 100,000 units of powdered penicillin into the mastoid cavity, immediately prior to closure with drainage, is a more satisfactory method. We have seen no evidence of irritation following the use of the penicillin powder even in cases where the dura or lateral sinus was exposed. Wound healing has been very rapid with a dry, healed incision in from six to ten days.

We have been privileged to follow and treat a considerable number of infections of the deep cervical spaces and fascial planes of the neck, particularly following fracture of the mandible, osteomyelitis of the mandible, dental infections, scarlet fever, erysipelas, and following tonsillectomy. These infections have included retropharyngeal abscess, infections of the parapharyngeal and submaxillary space, the submental triangle, and other deep cervical abscesses descending down the carotid sheath.

In instances of severe suppuration following fracture of the mandible or other associated dental conditions we have found that removal of the bony sequestra, area of osteomylitis, foreign bodies, teeth in the line of fracture, or infected, broken-off tooth roots by the usual dental procedure are still necessary before drainage ceases and healing occurs. In many of our cases of deep cervical cellulitis and abscess, penicillin therapy was started late in the course of the disease, after sulfonamide therapy had failed and probably after cell breakdown and early suppuration had already occurred. In spite of large doses of penicillin by parenteral injection (from 600,000 to 800,000 units over a forty-eight to seventy-two-hour period) practically all of these cases required surgical drainage. In some cases where penicillin therapy in adequate dosages was given very early and was continued over a long period of time, resolution of the infection without suppuration occurred. Penicillin therapy, however, is still indicated even in late cases, since it appears to aid in checking the spread of infection, helps to localize the infection, and its continued use following surgical drainage greatly speeds convalescence and promotes healing.

Penicillin therapy in Vincent's infection has not been effective in our experience. The associated staphylococcus, streptococcus, and pneumococcus infection has responded well to treatment, but additional anti-spirochaetal therapy with bismuth and neoarsphenamine has been necessary before the Vincent's infection per se was cured.

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## ABSTRACTS

### EVALUATE METHODS OF TREATMENT

Evaluation of the various forms of treatment of infantile paralysis is of great importance in determining the procedures to be recommended when an epidemic strikes, emphasizes a special committee appointed by the Scientific Advisory Board of the National Foundation for Infantile Paralysis in *The Journal of the American Medical Association* for May 5.

Commenting on the report by the committee, *The Journal* says, editorially, that "the amount of damage done to the nervous system, primarily, and to the muscle, secondarily, in this disease varies from one epidemic to another. Certainly mortality rates vary in different epidemics. Even the portions of the body that are primarily affected seem to differ; respiratory paralysis is much more frequent during some outbreaks than during others. The ultimate damage seems to vary according to the methods of treatment followed, yet assessment of both the immediate and the ultimate disability is exceedingly difficult."

### REHABILITATION OF EUROPE'S VICTIMS OFFERS STUDY OF WAR EDEMA

An opportunity to study the problem of famine or war edema is afforded in the rehabilitation of European countries, *The Journal of the American Medical Association* observes in its May 19 issue. This edema is one of the results of starvation. It is manifested by excessive accumulation of fluid in tissues, with swelling usually in the legs, and is widespread during war and famine. Until recently, *The Journal* says, biochemical and nutritional knowledge has been inadequate in determining a more specific cause than nutritional deficiency. The efficacy of high protein foods is generally acknowledged as causing the edema to disappear. The lowered serum proteins present in this disorder indicate a depletion of protein reserves of the body, which must be restored before cure can be effected. *The Journal* points out that results so far in trying to relieve nutritional edema by administration of B complex vitamins are conflicting, and the preponderance of evidence points to the dominant role of protein in the causation of this type of edema.

# INTERNAL FIXATION OF FRACTURES*

## THE "SPIKE" OPERATION

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The term "internal fixation of fractures" has been used to designate some type of device to maintain in position of reduction the fragments of a fractured bone. This term is a misnomer, for there is not any device or gadget nor any method of so-called "internal fixation" that will maintain the immobilization in the fracture line for a sufficient length of time necessary for healing without the use of some form of external fixation. The external fixation must be equally as efficient in giving immobilization as if there had not been any internal fixation. If a metal plate is used any torsion or strain exerted through the screws holding the plate will cause pressure upon the screws. This pressure in turn will create a necrosis or softening of the bone, and the screws will become loosened. Not only is motion then possible in the fracture line, but the screws may act as foreign bodies and create an inflammatory reaction at their site. Absolute and complete fixation for the period required for the formation of good callus is essential for a solid healing of a fracture. Thus the term "internal fixation" should be replaced by the term "internal suture" of fractures.

I am not opposed to the use of metal in fracture surgery, for experience has shown that it can be used successfully and without unfavorable reaction in the tissue. I am, however, concerned with the present trend of fracture surgery, to the effect that in any open reduction metal must be used—and in abundance, and I am especially concerned with the trend, both in teaching and in practice, that open reduction with the use of metal in a large percentage of fractures is good surgery. One will concede that certain types of fractures and old malunited fractures require open reduction. The flanged nail has changed the entire plan of treatment of the fracture of the neck of the femur. The dual plate in fractures of the shaft of the femur may be proved to be the best treatment in order to preserve the motion in the knee joint. As a general rule, however, one should attempt to obtain a satisfactory reduction of the fracture without an open reduction. The essential factor in healing is not a perfect apposition of the fragments, but that the reduction be immobilized by proper splintage for a period of time sufficient for physiological, complete healing with the fragments in good alignment. In adults it is necessary to have a larger contact of the ends of the fragments than in children.

The use of metal in fracture work is not new. In 1933 I reviewed the literature on internal fixation of fractures and found that the present-day conception of the use of screws, bands, wires, nails, bolts, and transfixation pins controlled by external bars is only a repetition of ideas presented many years ago. Figures I and II show a few of the gadgets used by our former surgeons, and which differ little from those advocated today.

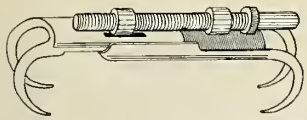
The majority of fractures are treated by the general practitioner and by the general surgeon. This has always been and will always be the status of this phase of surgery. Furthermore, most of the fractures treated by this group of physicians have had satisfactory healing, with an impairment rating not much, if any, greater than those treated by surgeons whose training and experience in fracture problems has been more extensive. Although the general practitioner and the general surgeon may treat satisfactorily the simple fractures in their community, not infrequently circumstances compel or invite them to do open reductions. In this phase of fracture work their knowledge of bone surgery and the hospital facilities available may create serious factors in the plan of treatment. It is the manner in which the reduction is maintained after the fracture line is exposed which presents the big problem in the surgical plan. Not only a lack of proper instruments and a lack of that special device which the case may require, but also the inexperience of using such a device can create a difficult situation if fixation is to be obtained by the use of metal.

The purpose of this presentation is to suggest a simple method of internal fixation which can be used by any competent surgeon in any hospital, and one requiring only those instruments which are a part of every surgeon's or hospital's surgical armamentarium.

The operation is based upon a simple physical factor. If a hollow tube (the shaft of a bone) is broken into two pieces, and the original position of the two fragments is restored—alignment and without rotation of one fragment, it is impossible to insert into the hollow center (medullary canal) any portion of the other fragment (see Figure III). This is due to the impingement of the bevel of one fragment upon the bevel of the other fragment. Therefore, if a spike is created on one fragment by cutting back the bevel of that fragment, except at the base of the spike, and if the spike is made slightly smaller than the hollow center of the other fragment, then this spike can be inserted into the hollow center of the other fragment to the distance that the bevel has been cut back.

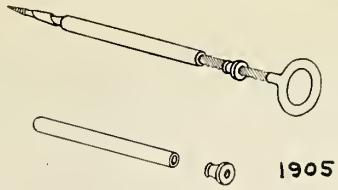
This operation has been called the "spike" operation. The skin is shaved and prepared for surgical

* Presented before the Surgical Section of the Indiana State Medical Association, at Indianapolis, on October 4, 1944.



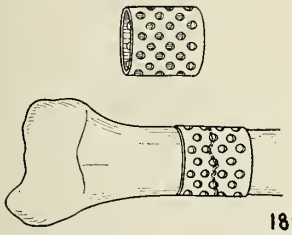
1840

MALGAIGNE'S HOOK.



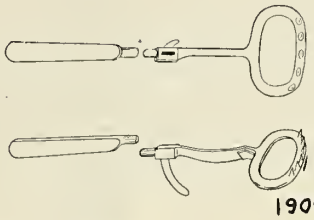
1905

GAILLARD - SCREW.



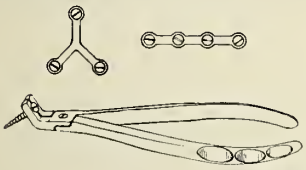
1893

SENN - METAL FERRULE.



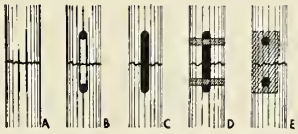
1909

MORRISON - DETACHABLE CLAMP



1905

LANE - METAL PLATE.




1913

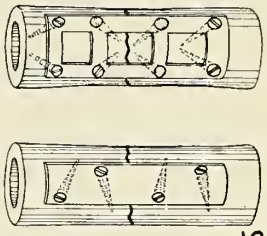
MAGNUSON - IVORY INLAY

FIGURE I

*A few of the gadgets used by our former surgeons, and which differ little from those advocated today.*

1914

PARHAM-MARTIN - METAL BAND.

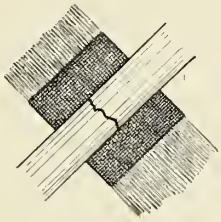


1909

HEY-GROVES - METAL PLATE.

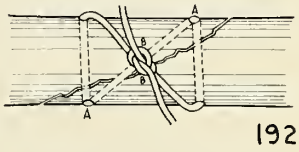
FIGURE II

*Gadgets used by former physicians in internal fixation.*



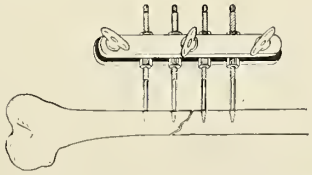
1914

STRAUS - CAT-GUT MAT



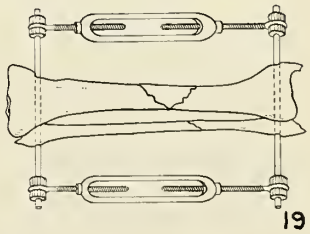

1927

PATTERSON - FASCIAL SUTURES.



1902

LAMBOTTE - EXTERNAL PLATE



1912

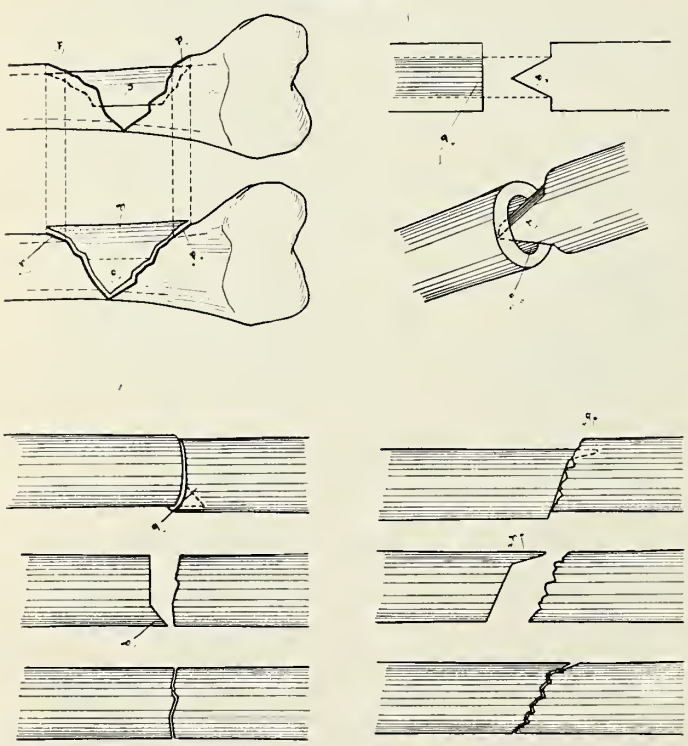
HEY-GROVES - TRANSFIXATION BOLTS

incision. Operation: The fracture is reduced to the best possible position of full length and alignment. It is not essential that the fragments be in contact. The extremity is then fixed with a plaster of Paris splint which incorporates the joints on each end of the fractured bone. A large opening is made in the splint over the line of approach to the fracture line. The skin is again cleansed and merthiolate applied. The exposed surface is isolated by packing towels or gauze strips under the edge of the plaster. The fracture line is exposed by careful dissection of the fascial planes. The fragment of the bone which is the more easily mobilized is grasped with a bone-holding forceps. The spike is then made on this fragment. In creating this spike the bevel can be cut back (about one-fourth inch is usually sufficient) with a bone rongeur the greater part of the circumference of the bone. As one approaches the base of the spike the remaining portion of the bevel should be cut with a bone chisel, cutting downward and outward from the top of the spike in order that the base of the spike shall not crack. This step is important, although should this spike be lost through a break at its base a spike can be created upon the other fragment. One then grasps the other fragment with a bone-holding forceps, and by angulating the fragment the spike can be inserted into the medullary cavity. If the spike does not enter the medullary cavity, or if it does not maintain a firm fixation, the bevel has not been cut back at all points or the spike is too large. Only these two factors can prevent the introduction of the spike into the medullary cavity or allow the spike to easily become disengaged from the medullary cavity. The wound is then treated with some type of chemotherapy (sulfanilamide crystal, et cetera, or filling the wound with ether), such as the surgeon may elect. All hemorrhage is controlled, the soft tissues are closed with loosely-tied catgut and the skin with silk sutures, and a dry dressing is applied over the wound. The opening in the splint is then closed with further application of plaster of Paris bandages.

FIGURE IV

*In fractures occurring at end of shaft, make a hole in the cancellous bone for the spike.*

FIGURE III

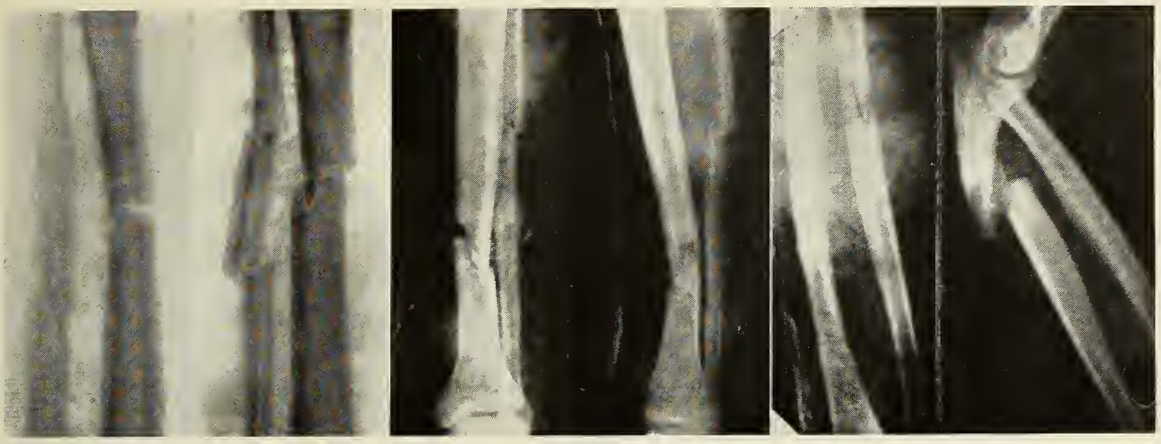


*Intramedullary spike operation.*

Should angulation be found in the postoperative x-ray examination, this easily can be corrected. Cut the splint almost the entire circumference at the fracture line, leaving only three or four inches to act as a hinge. The angulation is then corrected under the fluoroscope. In order to maintain the correction absolutely, put a piece of wood in the opening created in the splint and incorporate it in the plaster of Paris bandage used to repair the splint. In this manner one does not depend upon an assistant to maintain the correction.

In fractures of all of the long bones except the humerus there will be an overlapping of the fragments through muscle contraction. It is this muscle contraction which will hold the spike in the medullary cavity. Traction is contraindicated since it would put the spike out of the medullary cavity. In the humerus there is always a tendency for distraction of the fragment through the weight of the forearm and lower fragment, and also the arrangement of the muscle groups is such that muscular contraction does not tend

FIGURE V



*Spike operation in three types of procedure.*

to cause any or but little overriding of the fragment. If the spike does not give apparent firm fixation and will easily slip out of the medullary cavity, this condition can be controlled in a simple manner. Two drill holes are made in each fragment about one inch from the fracture line. A suture of No. 2 chromic catgut is then run through one hole, down through the medullary cavity to emerge through the corresponding hole on the other fragment, then across the outside of the cortex to the other hole and back through the medullary cavity to the hole in the first fragment, and tied tightly across the outer side of the cortex. This will draw the spike into the medullary cavity and hold it in that position. This same method can be used in the fracture of other bones if for any reason it is indicated.

If the fracture occurs at the end of the shaft where there is not any medullary canal in the cancellous bone, a hole can be made in the bone to receive the spike (see Figure IV).

In comminuted fractures in which a triangular piece of bone represents one of the three fragments, this triangular fragment can be used as an intermedullary splint (see Figure III). The apex portion of the fragment is cut off, and if the so-constructed bone splint is not long enough when inserted into the medullary cavities of each main shaft fragment a small portion of the end of these fragments is cut off (one-fourth inch is usually sufficient). This will give a fixation firm enough to maintain alignment and position.

This spike operation can be used in compound fractures. I do not use any metal in compound fractures as it increases the factor of infection. This viewpoint is not held by many surgeons.

The advantages of the spike operation are:

1. It can be performed by any competent surgeon in any hospital.
2. Special training in the use of metal devices is not necessary. Special instruments or devices are not required.
3. No metal or foreign substance is left within the operated wound.
4. Second operation for removal of any metal device is not necessary.
5. Traction is not required other than to maintain alignment.
6. There is a minimum trauma to the soft tissues.
7. Operative time is short.
8. Only simple instruments which are a part of every surgeon or hospital armamentarium are required. These consist of a dissecting outfit, retractors, bone-holding forceps, bone rongeur (not essential) and bone chisel and mallet.
9. Can be used in any type of fracture of a long bone except one severely comminuted.
10. Can be used in compound fractures.
11. Any shortening of the bone is not sufficient to create a disability.
12. Union is not delayed any longer than in any type of open reduction.
13. Simplicity.

820 Chamber of Commerce Building,
Indianapolis, Indiana.

## ABSTRACT: PENICILLIN FOR INFECTION OF THE BLOOD

The recovery of a patient from Staphylococcus albus septicemia, usually fatal in 90 per cent of the cases, has been effected with prolonged penicillin treatment, Robert H. Herbst, M.D., and James W. Merricks, M.D., Chicago, report in *The Journal of the American Medical Association* for March 3.

In the treatment of their patient who had developed septicemia after a kidney operation, the repeated administration of penicillin proved effective after sulfadiazine had failed.

# PERIPHERAL GANGRENE OF UNKNOWN ETIOLOGY

## A CASE REPORT WITH DISCUSSION OF THE DIFFERENTIAL DIAGNOSIS

EVART M. BECK, M.D.*

JAMES O. RITCHEY, M.D.*

INDIANAPOLIS

The factors incident in the production of peripheral gangrene are frequently difficult to define and classify. The following case is presented with a brief discussion of the differential diagnosis.

The patient, R. N., a white male, aged thirty, was admitted to the Robert Long Hospital on January 12, 1944, complaining of swelling and pain in the second toe of the left foot with an ulcerated area at the ball, and another extending under the base of the fourth and fifth metatarsals. The trouble had begun six to seven weeks prior with a blister on the second toe, which had opened spontaneously. Although the condition had become progressively worse the patient had continued to coach a basketball team.

The patient's past history was irrelevant until 1929 when he sprained his right ankle playing basketball. In the summer of 1931 a draining sinus developed on the right foot proximal to the base of the fifth toe. This toe was auto-amputated. He was seen on June 25, 1934, with a sinus at the ankle joint, amputation of the third toe, and an indentation at the site of the previous sinus. There was swelling and deformity of the right foot. X-ray of the right leg showed cortical thickening and destructive changes in the distal end of the right tibia and in the phalanges of the fourth toe with absorption of the phalanges of the fifth toe. The right leg was amputated and a diagnosis was made of (1) destructive arthritis of the ankle joint, (2) chronic osteitis and periostitis of the bones of the foot and leg, and (3) chronic inflammatory process with scarring about the ankle joint.

At this time the left leg was likewise distorted with indentation at the metatarsophalangeal joint of the fifth toe and loss of the distal phalanx of the third toe, although no etiological history of trauma could be elicited. X-ray of the left leg showed periosteal elevation of the distal fibula, hypertrophic changes in the distal tibia, and a destructive process at the distal portion of the second phalanx of the fourth toe with sclerosis of the phalanges of the fourth and fifth toes. Blood counts and urinalyses were normal. Wassermann was negative; Kahn and Kline, two plus. X-rays of the skull, chest, and spine were negative.

The patient was admitted to the hospital once because of a wound infection in the stump of the amputated leg, and several times because of peripheral necrosis developing in the left foot. During these admissions various tests were done. Serological tests were negative; sedimentation rate was 10, hematocrit 50, prothrombin time 22, and control 26 seconds. Serum phosphorus was 2.6, serum phosphatase 4.0; glucose tolerance normal, and B.M.R. —12. Therapeutically, the patient appeared to benefit by the use of intermittent venous occlusion.

On recent examination the second toe of the left foot was gangrenous, and there had been self-amputation of the fourth and fifth and the distal part of the third toes. The dorsalis pedis and the posterior tibial arteries showed good pulsation. Oscillometric[1, 2, 3, 4] examination of the arms and remaining leg was within the normal range. Oscillometric index[4] was 1. Neurological examination was negative except for the absence of the ankle jerk and slight hypalgesia over the dorsum of the foot.

There was no evidence of spinal cord disease. The cold pressor and the nicotine tests gave a normal reaction. The gangrenous areas had a lowered skin temperature approaching that of the room; other areas were within a normal range. The McClure-Aldrich test was done with equivocal results. On exposure to cold there was a definite lag in the time interval required to return to normal color and temperature as compared to controls. Histamine flare tests were interpreted as showing normal cutaneous response, although the wheals and the areas of erythema were about half that of two controls. Blood pressure was 130/80. Urinalyses and blood serological tests were negative. There was a leukocytosis of 12,000 to 13,000 with a normal differential. Bleeding time was one minute; clotting time, three minutes. Serum calcium was 10, and fasting blood sugars were 108 and 129. Van den Bergh was negative, direct and indirect reactions. Spinal fluid examination was normal, and cold hemolysin test was negative.[5, 6, 7] Examination of the foot by x-ray showed changes which appeared to be due to atrophy and osteocondensation.

* From the Department of Medicine, Indiana University Medical Center, Indianapolis, Indiana.

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## DISCUSSION

In peripheral necrosis one must consider many syndromes and disease entities which Abramson[8] has classified as follows:

I. Gangrene developing in a limb without previous significant peripheral vascular disease:
   - (A) Traumatic (main arterial limb).
   - (B) Embolism.
   - (C) Thermal factors.
   - (D) Chemicals or drugs:
     - (1) Carbolic acid.
     - (2) Lead.
     - (3) Carbon monoxide.
     - (4) Ergot, et cetera.
   - (E) Thrombosis of stasis.
   - (F) Local infections.

II. Gangrene developing in a limb with previous significant peripheral vascular disease:
   - (A) Infections:
     - (1) Thrombo-angiitis obliterans.
     - (2) Thrombo-arteritis.
     - (3) Luetic arteritis.
   - (B) Degenerative:
     - (1) Arteriosclerosis:
       - (a) Senile.
       - (b) Diabetic.
   - (C) Neurogenic:
     - (1) Raynaud's Disease.

In the differential diagnosis we shall attempt to conform to this classification. Pernio[9] is characterized by a lesion of variable size and type with a violaceous hue. The affected areas are proportionate to the temperature (cold) of the air and the position of the part, and appear on the dorsum of the hands and feet perennially. This case obviously does not conform to these criteria. Frost bite[10, 11] with attendant history of exposure, numbness, tingling, blebs, and erythema, with later gangrene, may be eliminated by a negative history, as may gangrene due to aminopyrine or ergot.[12, 13, 14] Embolic occlusion is characterized by a sudden onset of acute pain with pallor, coldness, and numbness of the distal parts. A moment's consideration of the history excludes this entity. Tests for cold hemagglutination were negative, and therefore we may eliminate gangrene associated with this condition.[5, 7] The patient's history of onset and circulatory tests contradict a diagnosis of thrombosis,[8, 15, 11, 16] which is slow in onset with symptoms of numbness, tingling, and fatigue. Thrombosis may affect both sexes and be unilateral or bilateral.

Trauma,[15, 11] we said, could not be eliminated by history. It has been recognized that injury of crushing or severe penetrating wounds may cause gangrene, but here is a history of a sprained ankle, a fall in a locker room on the amputation stump, and walking in a tight shoe—minor incidents in the lives of most people. It is true that mild trauma may cause gangrene, but only if the vasculature is sclerotic. Thus, the entity of trauma as the etiological agent is questionable.

In the second group there are three sub-groups: (A) Infections, (B) Degenerative, and (C) Neurogenic. Of the infections, let us consider thrombo-angiitis obliterans, or Buerger's disease. [12, 17, 18, 15, 19, 20, 18] This is a disease occurring in white males in an age group of 30 to 70 years. There is usually a history of smoking and migratory phlebitis. There is an absence of ulceration. Pain occurs at rest or as intermittent claudication. One of the most frequent initial symptoms is the coldness of one or more of the extremities. Tender, red, elevated areas may appear near the valves of the superficial veins and gradually disappear over a period of two to three weeks, to be followed by a new crop. There may be color changes of the Raynaud type. Although R. N. smoked, the effect of smoking on his blood pressure and skin temperature was nil. His oscillometric examinations were normal and pedal pulsations were always present and full. There were no color changes, migratory phlebitis, or endarteritis.

Endarteritis obliterans[17, 15, 18, 11, 20] approaches our clinical picture. Any sex or race may be affected by trophic disturbances and tingling with ulceration of the tips of the digits followed by gangrene. The circulatory function tests may be normal with efficient circulation in the legs in the presence

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[19] DeTakats, G.: Gangrene, *Surg. Cl. of North America*, **16**:317, 1936.

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of said gangrene. The only discrepancy is the need for a history of a burning sensation, numbness, and tingling which were not present in this case. In view of the repeated negative serological tests for syphilis, with the exception of a questionable positive in 1934, this disease may be eliminated from discussion. The gangrene of the gas bacillus also may be eliminated before the evidence of the tissue sections and the cultures with the absence of the systemic reaction and toxemia.

The picture of acute arteritis[16] is most often found in children following acute infections with sore throat, elevation of temperature, headache with a purpuric rash over the extremities, and leukocytosis. Ulcerative lesions with focal gangrene follow. R. N. did not conform to this clinical picture.

Periarteritis nodosa[16] is characterized by severe systemic symptoms along with secondary anemia, occasional eosinophilia, leukocytosis, and subcutaneous nodules. Peripheral thrombosis may lead to digital gangrene. This diagnosis could not be upheld by either the clinical or the pathological picture.

Since the pathological and the radiographic pictures of this case resemble the chronic diffuse sclerosing osteitis of Garre[21] we must consider it with infectious types of peripheral necrosis. The exact cause is not known, but it is thought to be due to an infection of low virulence. It is often seen in youth, and is usually in the shafts of the long bones, differing from the case in hand. A dull ache, worse at night, is present in the region of the affected bones.

There may be an elevation of local temperature with redness over the part. When the process is near the surface, ulceration of the skin may take place. Because the localization in this case was chiefly in the bones of the feet, and since there was no pain and no local temperature elevation, this case differs from Garre's osteitis.

In the second sub-group of this classification we find the arteriosclerotic manifestations of degenerative vascular disease. In view of the fact that the fasting blood sugars were normal and that there was a normal glucose tolerance curve we may regard the patient as a non-diabetic. Arteriosclerosis[12, 22, 18, 23, 15, 11, 16] occurs in the aged of either sex or any race. Pain is commonly present, and the feet are cold. The gangrene is localized and dry with symptoms of weakness and claudication, night cramps with rest pain, and absent pedal pulsations. Circulatory tests show poor results. This case was not aged, had had no pain, and had relatively good results with the vascular tests.

The third sub-group is that of the neurogenic phenomena. The radiologists have suggested leprosy and syringomyelia[16] as possible diagnoses in this case. The absence of evidence of damage to the nervous system, the cutaneous and neuropathic changes of leprosy, as well as the characteristic pathologic picture and a bacterial diagnosis of leprosy tends to exclude this entity. The characteristic sensory dissociation, muscular atrophies and spasticities of the patient with syringomyelia are also absent.

Raynaud's syndrome[24, 18, 25, 15, 16, 18] must be considered. It is described as a symmetrical, bilateral affectation of the fingers, toes, or tips of the ears.

There are specific color changes, blanching, cyanosis, and redness or erythema. The onset is influenced by cold or emotional strain, and the disease usually occurs in young women. Vascular tests usually show little change although permanent damage may occur late. R. N. did not at any time show color changes, and the onset of his difficulty was not influenced by cold or emotional strain. His vascular tests were normal. Scleroderma[26] of the vascular type is eliminated on the same premise as Raynaud's disease, in that most writers consider the changes of scleroderma similar, if not the same as Raynaud's disease. Erythromelalgia,[26] another of the vascular phenomena related to the nervous system, produces no gangrene.

After a consideration of the lesions producing peripheral necrosis we find several which almost conform in description to the clinico-pathological picture of this case; however, not one of them justifies the making of a diagnosis. It should be noted again that there are many cases of peripheral necrosis which defy an etiological classification.

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Above the thunder of a Pacific battlefront the Marines sang, "Get Your Gear On, We're Moving Out Again!"

In this Mighty Seventh War Loan, get that War Bond and help bring them back again!

*THE JOURNAL*
OF THE
INDIANA STATE MEDICAL ASSOCIATION
DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA
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JUNE, 1945

# Editorials

## THE COUNCIL ON MENTAL HEALTH

Indiana took a forward step when the recent General Assembly provided for a new central "screening hospital" for the mentally ill, to be located in Indianapolis. A further step in this direction was the appointment of the members of the Council, by Governor Gates. He named two physicians and a judge of one of our Circuit Courts—Dr. LaRue D. Carter and Dr. Norman M. Beatty, both of Indianapolis, and Judge John H. Morris, of the Henry Circuit Court.

The personnel of this committee is just about all one could wish—Doctor Carter, long-time engaged in psychiatry, Dr. Beatty with his background of public health service, and Judge Morris, with his almost eighteen years as presiding judge in Henry County, provide a board of unusual merit.

We are somewhat inordinately proud of the step Indiana has taken in this regard; the matter of mental health, of late an ever-increasing problem, has disturbed us most seriously. That there has been a marked step-up in the number of mentally ill, not only in Indiana but throughout the nation, is a recognized fact, and we believe that the "screening" process will be of more than material benefit—we believe it to be the answer to many phases of the problem.

Then, too, this new hospital, although small, will materially assist in the solving of the problem of what to do with our mentally ill. Today our five such hospitals are unable to carry the load. They are grossly overcrowded and seriously undermanned, professionally. There are too many instances over the state where patients are compelled to be cared for in county jails and other places until room can be found for them in one of our state hospitals.

As we understand the plan, this screening process will obviate the necessity for hospitalizing many of the cases examined and considered by this board, all of which will help to reduce the overload.

We have unbounded faith in the members of this board, two of whom we have known throughout their entire medical career, and the third, Judge Morris, has antecedents of such a character as to deeply impress us.

Governor Gates is to be congratulated on these appointments. They are quite in line with many of the appointments he has made in matters that affect public health, thereby increasing our belief that he means to do a real job in the improvement of public health in the Hoosier State.

## THE SEVENTH WAR LOAN

Comes again another War Loan, this being number seven, with a goal of *fourteen billion* dollars—a lot of money in any man's system of figuring. The campaign opened on May fourteenth and closes on June thirtieth. It goes without saying that the call will be met; the American people are fully awake to the war situation and know that even with the European phase apparently well in hand there still is a Pacific complex that will require a lot of money for eventual victory.

Too many folk, however, have a somewhat complacent attitude; the reason, "Oh, well, we are about to conclude the war in Europe, and as far as the Pacific matter is concerned, that soon will be taken care of," all of which is not true. As we have pointed out, the war against the Japanese—an all-out affair—requires additional men, additional materiel, and longer shipping distances, with increased costs.

That the American people are alive to the financial needs of the nation is evidenced by the fact that the previous six Loan Drives brought in more than *eighty-seven billion dollars.*

It is estimated that some twenty-seven million of our citizens are "tithing" in the matter of buying Bonds, an average of one-tenth of their income being set aside for bond purchases.

All this is accomplished with the generous support of our citizens. It requires a bit of personal stimulation to get some folk interested in Bond buying, so, we are told, some five million volunteers enlist in the various campaigns, many of whom are "door-bell ringers." More than a million places

throughout the country are prepared to issue Bonds to all buyers. In addition to all this effort, there is the advertising—all of which is gratis. More than two hundred forty million dollars' worth of advertising space has been donated by our newspapers and magazines.

After all, it comes down to a personal equation—what are *you* doing to support your country in this hour of need? Most everyone is making money these days. It is true that we are paying taxes as never before, but still there is more money in our pockets than most of us recall ever having had. What are we doing with it? We are buying more, and paying higher prices for what we are buying, yet we have money left in our pockets and in the bank. It is this money that should be invested in War Bonds—the best investment on earth—the safest investment.. In addition, it gives us the best assurance that *most* of the millions of young men now in service will be coming back to us one of these days.

We would suggest that every one of our readers make a recapitulation of his finances to see if he can not go a little bit farther in the purchase of War Bonds. Let's get this thing over with—*the War* we mean—but to do that expeditiously costs money, lots of it. Not only is it the patriotic thing to do; it is the first *must*—so let's do it!

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## WHEN "THE BOYS" COME HOME

"The Boys" referred to above are our Hoosier medics who are now in the armed services and who will be coming home after the war has ended and complete victory won. Those of us at home and in civilian life have a definite duty, that of seeing to it that the practices they left are restored to them, in the event they choose to come back to their home town, as more than fifty per cent already have said they wished to do.

A report on a survey made in this matter, by Lieutenant Colonel Harold C. Lueth, Medical Corps, U. S. A., and published in the April 21 issue of *The Journal of the American Medical Association*, gives interesting data on this subject. Almost fifty per cent of the medical men now in service have expressed a desire to return to their former locations and again take up their work. (These figures are taken from a list of 21,029 answers received as a result of a questionnaire sent out by Colonel Lueth. This represents approximately one-third of the medical officers on duty.

Here we have a cross section of the opinion of our fellow practitioners, many of whom have been away from their homes one to four years, with the prospect of this period being lengthened. The fact remains, however, that the majority of these men want to come back home, a wish which we all should encourage and expedite to the greatest degree.

At the time they left for the armed forces, several medical societies, by resolution, provided that appointments held by men going into service should be open to them upon their return. In this there was a general agreement on the part of the industrial and insurance organizations, most of whom announced that returning servicemen would be given their old posts.

But there is another phase of the question that demands careful study, with resultant action; we refer to the servicemen who for one reason or another have been discharged from service, and instead of returning to their former homes are seeking what seems to them to be greener pastures. This is particularly true in our industrial areas where medical men remaining at home have been exceedingly busy. These locations are looked upon with much envy on the part of some returning servicemen.

Just how the problem is to be best handled remains somewhat of a question, but the experiences in several of our larger centers would seem to indicate that proper steps are being taken to safeguard the men who will be coming back one of these days. One of the larger societies already has decreed that membership in the local society will not be materially increased until after the war, which, of course, means that a chap coming from another state, or from another section of Indiana, will find a rather cold reception in case he wishes to locate in that county. He will be told, frankly, that the county has several scores of men in service, all of whom wish to return there, and that outsiders coming in at this time will not be very welcome.

We do not object to men coming into areas where there is a definite need for physicians, but we do object to the fact that these outsiders are coming in and concentrating on areas irrespective of need for medical services in those areas.

We have talked to two or three such men from a neighboring state, and when asked why they want to come into Indiana, their reply invariably is that they feel they can much sooner establish a practice there than by returning to their former home.

We are strongly opposed to these men coming into Indiana at this time, "muscling in" would seem to be the better expression. We suggest that each of our larger county medical groups carefully look into the matter and take such steps as are necessary for our own protection. These chaps are seeking new pastures and not looking for small-town or country practices; they want the larger centers, the industrial areas, if you please. If the suggestion is made that they locate in some country town they shrug their shoulders and state that that is not what they want; they want the city practice. It is our opinion that when all the Indiana servicemen have returned to their homes that the Hoosier state will be pretty well taken care of, medically, and that for the time being, at least, we should not encourage an influx from other states.

## DOCTORS AND BOOKS

Most medical men are great readers, so we are advised by librarians, yet there are too many who do little or no reading—not even current medical literature. (We have heard a few admit that they *never* read medical journals.)

But there are many who really are entitled to the cognomen of "Bibliophiles," men who make books of a certain sort a fetish. They will go to undetermined lengths to obtain a first-edition volume of some medical work long out of print.

These men do not stop with medical writings; they are up-to-the-minute on current literature. We have seen many libraries that we instantly coveted, and hoped that in due time we might become the possessor of such a noteworthy group of good books.

The late Harvey Cushing is an outstanding example of such a doctor, who found time to indulge in specialized book-collecting. His store of works pertaining to Ambroise Pare never has been equalled, and from these writings he wrote the immortal volume, "A Bio-Biography of Ambroise Pare." Such a book will live forever, and it is exceedingly unforunate that the edition was strictly limited, only a few hundred copies being published following the death of the author.

It is most refreshing to read of the work being done by a group of physicians and laymen, called the Billings Club, whose purpose it is to enjoy the fine old books on medicine and allied subjects, particularly incunabula—books of the cradle period. This club has its locale in Cleveland, and the impetus for its organization was the arrival in that city of a large number of such volumes from the Army Medical Library early in the first days of the war.

The club was named for John Shaw Billings, who built up the rare book collection in the Army Medical Library. Soon after the library had been established in Cleveland the members of the club hit upon the happy and expedient plan of having members take turns in arranging exhibits of books upon the subject in which they were most interested.

The first of these exhibits had to do with the immortal work of Vesalius, "De Humani corporis Fabrica." It was pointed out in this connection that Galen, some thousand years before, had written what was then regarded as the last word on the anatomy of the human body.

Dr. Torald Sollmann, chairman of the Council on Chemistry and Pharmacy of the American Medical Association, and dean emeritus of the Western Reserve Medical School, prepared an exhibit of "herbal" books, including some of his own.

Another exhibit concerned the early development of the microscope, going back to the days of the old Dutch lens-maker, Anthony Van Leeuwenhoek, who was the real pioneer in microscopy.

From time to time other exhibits will be arranged, each being authentically based on the books themselves. Thus, those fortunate enough to live near the Ohio City, or who visit it, will be well repaid for a visit to the exhibits as they are announced.

We often have felt that if available old books were brought together in sizeable communities they would prove of incalculable benefit to those interested in book lore. The Cleveland setup seems to us as being just about perfect, and we wish it were near enough for us to take full advantage thereof.

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## THE HAPLESS MONON

Yes, this is the tale of a railroad—an Indiana railroad, if you please; a story about the near passing of a Hoosier institution, one that helped make history for our state. For the Monon Railroad, we would have you know, is really an *Indiana railroad;* it has its beginning and its ending all within the confines of the Hoosier state. It runs some three hundred miles, from the state line at Hammond, to the Ohio River at New Albany. Then there is, of course, the Air Line, as it used to be known, extending from Monon, in White County, to Indianapolis—about ninety-five miles, making almost four hundred miles of Indiana railroad.

Most of our life we have known the Monon, first known as the Louisville, New Albany and Chicago, and latterly as the Chicago, Indianapolis and Louisville. We recall many of the landmarks in its history. Along in the nineties the road purchased two huge passenger engines, numbered 111 and 112, these being at the time the wonders of our section of the country. We recall that every evening when one of these big engines puffed into the station at Frankfort, nearly the whole population was at the station to see the "monsters." Later on they were given new numbers, and were used as switch engines.

Some years later, after we came to Hammond, we became better acquainted with the Monon; we got to know many of the higher-ups in the official family. W. H. McDoel was the president of the line at the time, and he, along with other Chicago tycoons, had driving horses. These men organized a "Gentlemen's Driving Club," and many a time have we gone to the old Washington Park race track to witness the race meets put on Saturday afternoons, in the summertime, by these gentlemen. Each drove his own horse, using the old-time high-wheel sulky.

Later on, Judge Field, formerly of Rensselaer, became head officer of the railroad, which position he held for many years, being succeeded by Harry Kurrie, also of the same Jasper County city, and a former law student in Judge Field's office.

Of late years, however, the Monon fell into evil days; all the old heads were gone and a new set took over, coming from two railway companies in the South. It is our personal belief that the newcomers cared little for the Monon and Hoosier traditions; they took off a train or two; later

took off two more; and still later more trains were annulled. Even the famous "Hoosier Dinner," the best layout for the price — $1.50 — in the nation went into the discard. The famous Monon lounge car was cut in two, one end being the lounge, and the other the semi-diner. Joe Chicoine continued in the capacity of a steward; the other, Bert Hart, being dropped to make room for a higher-seniority man from the commissary. George Harris and a few other old-time waiters hung on, and still are serving the few passengers that ride the remaining train to Indianapolis, leaving Hammond at 8:52 A. M., and leaving Indianapolis at 2:10 P. M.

Thus, do the north-enders, particularly Lake County folk, find it more than inconvenient to go to Indianapolis by train. Gas is, of course, out of the question, and unless we go into Chicago to get a train we just don't go. Both the night train to Indianapolis and to Louisville have been discontinued, shutting us off from French Lick, unless we take a local and go from Orleans via bus.

The Indiana press is pretty sore about the debacle of its only real Hoosier railroad, and efforts already are being made to do something about it. We doubt that much can be done since those in charge have shown little interest in what Indiana folk think about the manner in which the line has been operated in recent years. However, it may be that the time soon will be at hand when the line will have to be sold, and perhaps the new owners will have a different view about the whole matter. Personally, when we heard of the discontinuing of so many trains we shed a reverent tear and said, "Goodbye, old-timer; we knew you well, and thought well of you!"

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# Editorial Notes

Prepayment medical insurance, it seems, just will not down, the lay press continuing to insist that some such arrangement be made, and that it be made soon. Indiana Medicine continues to try to work out some plan that will be generally acceptable, and it is hoped that soon a workable plan may be presented to the state association, one that also will meet with the approval of our citizens.

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What to do about maintaining sufficient medical staffs for our state hospitals long has been a problem, but now it has become most acute. In one such institution, with a patient population of 2,553, there are but two physicians on the staff. Increased pay and more attractive living conditions would help to alleviate this need to some degree, but still there is the problem of a shortage of medical men who are interested in that service, as mentioned in another comment in this issue.

Just now comes the news of the fate of the Duce of Italy, and although it is late we want to add our mite of editorial comment thereon. We do not recall that we ever were in accord with "mob violence," particularly when carried out with such apparent vengeance, but if ever a human being got his exact, just deserts it is our opinion that Mussolini got exactly what was coming to him, and in a manner that does not disturb us in the least.

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Trained occupational therapists are one of the crying war needs at the present time, according to the United States Department of Labor. It will be remembered that at the September session of the Indiana State Medical Association there was a showing of just what this means in our rehabilitation program. There is a shortage of trained therapists, and steps are being taken to remedy this. Additional schools have been opened for that purpose.

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We are in full accord with the pronouncement of Dr. Charles W. Meyers, superintendent of the Indianapolis City Hospital, concerning the matter of accepting patients in that institution from areas outside the city. His announcement states that after May first he will have to enforce the law in this regard, which means that only citizens of Indianapolis proper may be admitted to the City Hospital. For as long as we can remember most anyone could gain access to this hospital, and many abuses will be corrected if the new rule is enforced. Marion County, it seems to us, is fully able to properly care for such cases as arise outside the city.

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Medical conventions continue to be "out," so far as the ODT is concerned. Each month we find some state medical journal carrying the news that that state will not hold its annual convention, nor will there be an official session of the House of Delegates. Holman Taylor, secretary-editor for the Texas State Medical Association, in the current number of his magazine bemoans the fact that the Texas society constitution makes no provision for such an emergency. It is safe to say that few, if any, state groups have foreseen such a predicament; hence, we are all in the same boat, as far as that is concerned. At present it appears doubtful that there will be any letup in the restrictions, even though the European phase of the war seems about to be ended. It is maintained that transportation will be more restricted for civilians, after this V-E Day, than at the present time, what with millions of our overseas troops coming back here, only to be shunted into the Pacific area. It behooves us to begin planning some sort of a program whereby a small group can get together and carry out a curtailed program—election of officers, the presentation of certain committee reports, et cetera.

Disciples of Gambrinus, meaning those who like to "blow the foam off the top," are quite concerned just now. With the coming of the new State Liquor Commission there are many new regulations, particularly in the matter of the beer business. The wholesale dealers over the state were for the most part members of the Democratic party, so when the GOP took over there was much scurrying about to see what could be done in retaining their permits. For a time it looked as though there would be a wholesale housecleaning, but matters have shaped up a bit differently, and many of them will, at least for a time, continue in business. A few who were granted thirty-day permits talked of going out of business right now, which threw quite a scare into the beer-lovers in those communities. There is nothing like the "likker question" to bring about many controversies, and here in Indiana we seem to have them all.

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Garden notes for May are not all that they should be. With the balmy days of April, when it looked like a sure-fire early spring, we dug up our garden clothes and set out to the backyard, there to beat the gun in certain vegetable growing. Then came the frosts, chill, and wet days, and growing things took a siesta. No, we have not lost any of our early plantings, but most of them are in the stalemate stage, just waiting for more propitious weather. We do advise everyone to do a bit of gardening, this year, even if it is only to supply the current table. We have a very definite notion that the OPA will crack down harder than ever in a few months, and that things to eat, things that were commonly to be had almost any place and at any time, will be sold via the "point" route, and most of us already know what that means.

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Last month we ran an editorial on "Tommy Hendricks," well known to Association folk as the "Blond Boss," "Senator Hendricks," and what have you. We must have been right about this, since Lowell Nussbaum, editor of the "Inside Indianapolis" daily column in the *Indianapolis Times*, has this to say:

"Tommy Hendricks, executive secretary to the Indiana State Medical Association, returned this week end from Portland, Oregon, with some stories that left his fishermen friends gasping with envy. Tommy went to Portland on business for the American Medical Association. The day a meeting was scheduled the chairman announced there'd be no session as the smelt run was the biggest in years. Tom went along down to the sandy river, and just stood there, amazed. He says the water was black with fish for a mile and a half. People were catching them with seines, hats, baskets and what have you. The next day he saw smelt on the hotel menu and ordered some. He got four of the little fish and paid a dollar for them. Personally, he thought the fish smelt." As usual, Tommy was himself—a bit Scotch, you know!

*The Voice O' Labor*, "The Voice of Union Coal Miners," published in Morgantown, West Virginia, devotes its entire edition for March fourteenth to a denunciation of the increasing number of dams and power projects by the federal and state governments. The eight-page publication sets forth many good arguments for its stand, chief of which is, of course, the fact that such power dams reduce coal consumption. The editors feel, as do many other folks, that too many thousands of acres of arable farmland are forever covered by these artificial lakes.

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A southern Indiana county found itself short of medical men when the war broke out; however, the few remaining bent every effort to carry on the work. As we recall it, there were some seven doctors in active practice in the entire county. Death took its toll, and recently there were but four doctors left in the community. So, when a recent graduate of the Indiana University Medical School chose to open an office in that community he was received with open arms, the local paper taking occasion to comment on the matter at quite some length.

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The Council on Pharmacy and Chemistry, of the American Medical Association, has appointed a committee to confer with the Advisory Committee of the Cooperative Medical Advertising Bureau, "with respect to problems of mutual interest." This committee is composed of Dr. James P. Leake, of Washington, D. C.; Dr. Stuart Mudd, of Philadelphia, Pennsylvania; Morris Fishbein, of Chicago, and Austin Smith, secretary of the Council. The Cooperative Committee consists of Olin West and Will C. Braun, of A.M.A. headquarters; Stanley B. Weld, Hartford, Connecticut; Walter E. Vest, Huntington, West Virginia; L. Fernald Foster, Bay City, Michigan; John Bouslog, Denver, Colorado, and E. M. Shanklin, of Indiana. There has been some controversy regarding advertising published by some of our state journals, and this new committee setup is the outcome of several conferences in the matter.

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At long last physicians as well as the general public have learned that penicillin is not a "cure-all," that while it has almost miraculous effect in certain conditions, chiefly of the infective variety, there are definite limitations for its use. In passing, we note that this same general public is fast becoming acquainted with the newer concepts of medicine and surgery; we all have patients who talk about this or that new drug, or of new types of appliances used in the treatment of many conditions. They gain this knowledge from reading the daily papers and magazines, along with the health talks given via the radio. However, much of the latter is of the ballyhoo type. Thus, the laity had come to believe that penicillin was the Simon Pure panacea for which they had long waited.

# President's Page

## WELDING MEDICAL FORCES

During the latter part of April the Michigan State Medical Society was host at a two-day meeting to the presidents of seventeen state medical associations. This conference had been previously arranged through the medium of a telephone conference hookup, which served to propose and define the purpose of the meeting. The unique method employed resulted in 100 per cent attendance, and in every way the meeting was gratifying and successful. Michigan is to be congratulated upon initiating a forward step in consolidating the feeling that should exist between state associations, and in presenting a program that should go a long way toward solving many of the problems confronting the medical profession.

At the luncheon meeting on the first day a discussion on "Planning Health Legislation" brought out the necessity for offering, selling, and operating voluntary health insurance plans, and the need for developing sound health legislation through the introduction and sponsorship of basic principles and specific recommendations to those in a position to properly present them for legislative action.

As a result of the discussion it was recommended that the various state medical societies should set up drafting panels in order to consider these questions, and advise the American Medical Association, through its Council on Medical Service and Public Relations, of their wishes in regard to national health legislation. Correlation of the various ideas from the different states was to be attempted and a consolidated viewpoint presented for definite action. In line with this proposal the following men have been asked to serve on this panel: Drs. McCaskey, Ferrell, Romberger, Wright, Hamer, Oliphant, and Forster. It is to be hoped that consideration of this problem will bring forth many ideas that may be welded with the ideas of other state organizations, and eventually, through concerted action prove an effective method of obviating compulsory health insurance schemes.

The afternoon was devoted to a tour of the Michigan Medical Service setup. It has been a long time since our first visit to Detroit to study this plan, a matter of some five or six years. The progress that has been made is truly remarkable. Expansion from a two-office suite to the occupancy of many floors of a large office building cannot be accomplished without the background of a great deal of progress. Michigan is successfully operating their plan, and it is a source of great satisfaction to them, and to anyone who visits their offices, to find that here is a definite answer to the question as to whether or not the medical profession can provide a health insurance plan that affords adequate medical care to the people at a cost that can be budgeted within their means.

In the evening we were entertained at dinner and introduced to the pioneering results of a commercially-sponsored radio broadcast of the Michigan State Medical Society. This program, paid for by the society, combines the pleasing effect of good music and fine singing, with the presentation of a well-delivered and timely message from "American Medicine." The discussion which followed this presentation brought out the belief that "The commercial broadcasting program as now developed and enlarged places the medical profession in the public relations field in a big way — we cannot help but feel that this project is making a valuable contribution to the preservation of American Medicine."

The idea was then presented that a hookup of the most powerful stations in key cities of the various states represented at the meeting would enhance the value of such a program to the extent of being able to carry the message of American Medicine to a vast radio audience, and in this manner, "keep alive in the minds of the public the need for the preservation of the traditional private physician-patient relationship and the elimination of government and bureaucratic administration in the private practice of medicine."

Unanimous approval was given to a motion that a committee be appointed to study the feasibility of commercial radio broadcasting as related to the various states represented, and to make recommendations for coordinating and cooperating in the development and carrying out of such a program.

Michigan again is to be congratulated upon its unique approach, its forward-looking and aggressive measures, and for the splendid manner in which it conducted this well-planned conference. It has indicated its progressive spirit, and it has led the way in adopting a positive stand to the end that the principles of American Medicine shall be preserved.

N. K. Forster

# ON MAKING YOUR WILL

ALBERT STUMP
INDIANAPOLIS

Wills are rarely broken. It is not true that where there is a will there is always a lawyer to break it. A few years ago surveys were made in several counties in the East to ascertain how much of a chance there was that the making of a will would prove futile. They found that in New York County six wills out of one thousand were broken during the period studied; in King County, New York, four out of a thousand; and in Middlesex County, Massachusetts, two out of 1746 wills probated in one year. I do not know of any statistics available in Indiana on that point, but the records certainly would show a very low percentage of wills that did not stand and were not executed exactly as written.

However, the fact that wills generally stand does not mean that everyone needs a will. Before determining to have a will prepared one should have clearly in mind how his property would be distributed if there were no will. The law provides for the distribution of every bit of property left by a decedent. To set out all the laws of descent and distribution would require probably seventy-five to one hundred pages, for the laws cover every conceivable situation, and there is no condition under which a person may die leaving property which is not covered by those laws.

Because of the large number of different situations that might exist, it would be well for any person having property to obtain from his attorney information as to the manner in which it would be distributed under the law in his individual case. As a general proposition it can be said that the law gives consideration to the persons whom people generally recognize as the natural objects of their bounty, so the distribution of one's estate will go to his family—meaning, by the word "family," his wife, children and grandchildren, if he has a wife and living issue; or his father, mother, brothers, sisters, nieces, nephews, uncles, aunts, and cousins, if he has no wife and no living issue. If he has no relatives at all, then the property goes to the state.

The statutes of descent and distribution will be found to make what would appeal to most people as a very fair distribution of property if the beneficiaries occupy reasonably equivalent situations, that is, if they are reasonably entitled to the same treatment. Equality of distribution to those in the same classes of heirs is the general intent of the law.

Whatever is taken under the law becomes the property immediately of the distributees, upon the closing of the estate, which can be accomplished generally in about one year. The law does not make provision for future interests, except that where there are children under twenty-one years of age it makes provision for guardians whose duty it is to conserve and administer the property until the children reach the age of twenty-one years.

Whatever provisions one desires to make to guard inexperienced members of his family against loss of the estate through mismanagement, or to make certain an income for the future, must be made through a will or through some kind of disposition of property during one's lifetime.

Those who have substantial estates generally make some provision for the safeguarding of the future of their dependents, beyond what would be provided by allowing them to have the estate as a whole immediately upon the death of the person owner of the estate. Trust arrangements are quite common. There are many plans under which property may be disposed of in trust, to be held by trustees for the benefit of dependents. In this manner provision for education, or for the old age of survivors, or against their improvidence, may be made if the property placed in trust is sufficient in amount to make certain that the income from it together with the property itself, if that is necessary, will be adequate to accomplish the purpose intended.

Thus, under the law, one who has acquired property may exercise some control over it beyond the term of his own life. To set up a plan for a control through a trust instrument, that would last over a long period of time, requires a careful study of the purposes intended to be accomplished, the nature of the estate itself, and the laws regarding future interests, if the purpose is to be achieved as intended.

There are circumstances where it is wiser to make distribution of one's property while he is living than to attempt to make it through a will. Distribution may be made while living, in such a manner as to subject the estate, or the part deposed of, only to gift taxes, where the same distribution to take effect upon death would leave the estate subject to inheritance and estate taxes. The latter taxes are considerably higher than the gift taxes.

A wise determination of whether one should make a will, to what extent his property should be disposed of by will, and to what extent by gift during his lifetime, involves a thorough knowledge of the estate involved, the problem of taxes, and the purposes intended to be accomplished.

It is impossible to do more in this article than to suggest the wisdom of giving consideration to the disposition of an estate. If one dies without a will it will be distributed according to law. The persons who may be appointed as administrators will be selected by the Judge having probate jurisdiction in the county in which the person resided. His choice of administrator will be governed by the statute, which provides that letters of administra-

tion shall be granted in the following order of preference:

1. To the widow or widower.
2. To the next of kin.
3. To the largest creditor applying and residing in the state.
4. If no person thus entitled to administer shall apply within twenty days after the death, then to a competent inhabitant of the county, appointed by the clerk, if the court is in vacation, or by the court if not in vacation.

Those entitled by preference to administer an estate must be appointed if they apply for such appointment within the time limit.

Wills are sometimes made for no purpose except to appoint an executor. Under such a will the executor named, unless he refuses to serve, must be appointed, and he then has the duty to administer the estate in accordance with the law.

There is no advantage in not making a will, on the ground that without a will expenses of administration of an estate may be avoided. The administration of an estate is no more burdensome, ordinarily, with a will than without a will, and no more expensive.

If there is a will it must be offered for probate. There is no law that requires an estate to be administered, in the absence of a will. But if there is real estate involved there may be difficulties in regard to the title if there is no administration. If there are stocks and registered bonds to be transferred, administration is generally necessary in order to satisfy the rules governing the transfer of such stocks and bonds. And if there is no administration there is always the possibility of controversies developing among those who distribute the estate among themselves, if that is done without a final determination that it was done properly and finally. So, under practically all circumstances there should be an administration of an estate, especially if it is of substantial value.

Further articles will follow, touching upon the general problem of estate conservation—but without any intention to deal with these subjects in a manner other than to suggest the general nature of the problems involved, and thereby help you to determine whether you should do anything in regard to your own estate.

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# TAYLOR EPIGRAMS

E. M. SHANKLIN, M.D.

HAMMOND

Some time ago, in commenting on the passing of Dr. B. M. Taylor, long-time secretary of the Jay County Medical Society, we spoke of the little quips with which he closed his notices of meetings. There was a quaint sort of personal philosophy in these, and those fortunate enough to be on the mailing list looked forward to the monthly cards. At the time we stated that some of these would be reprinted in THE JOURNAL. We regret that we will not have space for all of them, for each one is deserving of a permanent place in the annals of Indiana Medicine, but the ones we are publishing are used verbatum:

It is about as difficult to keep from acting like a fool as it is to keep from looking like one.

The first case of seasickness was when the whale vomited up Jonah.

A half-drunk smart Alec asked the secretary what his business was. The secretary replied that he was a physician. The half-drunk nut replied, "Well, that's a good racket, alright," The secretary is still scratching his head and wondering how much truth the simpleton spoke!

A skunk and a quack never become allergic to their own stink.

Everything has been improved but a man's stupidity.

The loudest advocates of socialized medicine are those who live like millionaires and pay like paupers.

The automobile has done five things: encouraged necking, disseminated G.C., aided the undertaker, increased thievery, and put the horsefly and tumblebug out of business.

There is more to medicine than you will find in the textbooks.

Don't frown—smile; the Lord showed partiality when he let you live the year out.

We cannot change yesterday; we cannot prevent tomorrow; but we *can* do our best today.

No matter how full the head is, there always is room for common sense.

If we say very much, we must talk with our heads instead of our mouths.

Judgment is the easiest thing to use—if we have it.

A diploma is just a license to use borrowed knowledge.

There are two big "D's" in Medicine—Dollars and Diagnosis; in which are *you* most interested?

Most of us doctors are like wasps—bigger when hatched out than at any time thereafter.

No one loses his head; it always was lost.

Patients with chronic ailments make careless doctors.

Columbus discovered two things at one look—America and syphilis. Politicians have about eliminated America, but syphilis is on the increase.

We are too deaf to hear the music, and too blind to see the beauty in a raindrop.

No incision ever removed an exaggerated pain.

The third scar on a belly, unless put there in a street brawl, indicates somebody was mistaken.

Dr. R. A. Solomon, of Indianapolis, had been invited to address the Jay County group. Secretary Taylor said this about it: "Owing to the uncertainty of the weather and the high cost of transportation, he will not bring his one thousand wives."

A medical student was asked as to whom the Eskimo might be. The answer was, "God's frozen people."

The secretary is reaching his second childhood; he fell out of bed last week.

Sense is worthless unless it has intellect for connective tissue.

If you find nothing new in every case, you have cerebral amaurosis.

The shotgun was made because of poor marksmanship with a rifle.

Scandal and gossip require no salesmanship to sell to the public.

A thousand-dollar car and a ten-cent brain make both look cheap.

The truly great are made so by the discipline of their failures.

Dr. Max Bahr, head of the Central State Hospital, addressed the Jay County group. Dr. Taylor commented on that, saying, "Dr. Bahr will feel perfectly at home before an audience of Jay County doctors. Bring your wife to this meeting; after listening to Dr. Bahr she will understand you better."

The only way to become and stay a bigshot is by accurate aim.

Idiots and feebleminded are the only ones who have no worries or do not learn by experience.

Guesswork is all right on a punchboard, but all wrong in the abdomen.

Experience is not in the number of cases seen, but in those analyzed.

If you want to know a man's religion, watch him work.

A bank account and a brain will have overdrafts if nothing is added to them.

Rudeness is the "B.O." of bad breeding.

A specialist too often gets to be so highly trained that he loses sight of the patient.

Prospecting for gold is child's play, compared to prospecting for truth; gold fluctuates, truth increases in value.

Brains are not always a prima facie evidence of intellect.

No one is big enough to successfully dispute the right of way.

Safe driving requires an open mind and a closed mouth.

Coroner Perry had *one* inquest in January, and bought a brand new Ford V-8 sedan. We thought the undertaker usually stripped the victim.

Diagnosis is the interpretation of the end results; the most beautiful picture in the gallery is the predisposing causes—why they get that way.

The Democrats called a moratorium on everything except gonococci, spirochaetes and obstetrics. They are still working full-time shifts.

Duck supper at 6:30—you bring the ducks.

Genius is born and then cultivated by made opportunities.

If anyone closes his mental door, no amount of TNT can open it.

The golden fruit of experience ripens only when roots draw deep from the past.

The more you coddle a pig, the bigger hog he becomes.

We doctors furnish the best clinical evidence of head injuries.

Experience is one thing that is never sold on credit—it is cash and carry.

Hyperemesis gravidarum started the slogan "She Can't Take It."

The quack is the only cocksure fellow.

We should be as up-to-date as Aesculapius; he kept careful case histories centuries ago.

Money will buy most everything except good breeding, good taste, brains, character, and high ideals.

A Latin teacher asked, "What is pax in bello?" A doctor answered, "It is freedom from indigestion."

Anything that is born of prejudice has a scrub dam and sire.

The less we know, the more positive we become.

If you are never fully satisfied with your efforts, you are well on the way to becoming a good doctor.

An act of stupidity is a hint to take stock of oneself.

The bigger the man, the easier he can fit in small places.

The secretary wishes he had a "tough hide and short recollection." He is just naturally sensitive.

The test of a real surgeon is not in how long the patient was on the operating table, but how long he is on earth thereafter.

Speed is all wrong unless guided by thoroughness; this applies to scalpels and steering wheels alike.

If our living tomorrow depended upon our good deeds today, how many of us would have died yesterday?

The Indianapolis Medical Society *Bulletin* ads contain two undertakers and one florist. It should have a monument man to make the service complete.

Straight thinking is the shortest distance between two points.

A good diagnostician is always a pessimist; he looks for the worst.

Ticks were sit-down strikers long before labor unions.

Dental cripple often begins—not with a pink toothbrush but with a visit to just a dentist.

The best dentist is one who gets out of a mouth without leaving any tell-tale tracks.

A little learning is a dangerous thing if put into practice.

Ignorance has an overhead that will bankrupt anyone.

If you jump at conclusions, do not light on the patient.

Are we doing our best? Look at the pond lilly in a stagnant pool.

Arithmetical progression: the more a fellow owes on his car the louder he honks his horn.

There never was a boil in a convenient place.

Snakes and politicians always leave crooked tracks.

Most of us would be good doctors *yet* if medical science had not advanced.

Common sense and drugs are never incompatible.

Something to think about: Did bean beetles become bean beetles because they were allergic to cabbage?

One skunk stinks just as "loud" as two.

The test of a big man is to work well with the man he dislikes.

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## ABSTRACT

### NEW DRUG HOLDS PROMISE IN TREATMENT OF TYPHOID FEVER

A promising new drug, related to penicillin in its germ-killing power, has been found useful in the treatment of typhoid—a disease for which heretofore there has not been a treatment of any value, it is reported in *The Journal of the American Medical Association* for May 19.

Hobart A. Reimann, M.D., William F. Elias, Ph.D., and Alison H. Price, M.D., Philadelphia, studied effects of the drug during a local typhoid epidemic in December, 1944. About sixty cases with eight deaths were reported during the epidemic, all of them arising from a typhoid carrier in a bakery. Because amounts of the drug were limited, only five patients were selected for treatment and study.

The drug, streptomycin, is a nontoxic substance which, like penicillin, has an inhibiting or destroying action upon bacterial growth. It acts, however, upon some disease-producing bacilli on which penicillin has no effect, including Eberthella typhosa, the microbe which causes typhoid.

Of the five patients treated by hypodermic injection with streptomycin, recovery took place in three during treatment. The authors point out that different strains of this germ vary in their resistance to streptomycin. This may explain why not all of the patients responded to the new treatment.

# HOW LOCAL SOCIETIES ARE MEETING PRESENT EMERGENCIES*

O. E. WILSON, M.D.

ELKHART

The information needed for the preparation of this paper was obtained from the replies to the questionnaire which I recently sent out to each county medical society secretary. Replies were received from fifty-nine secretaries, a seventy-per cent response. The questionnaire was sent out in an effort to learn what the individual society is doing in meeting the problems of medical care in the local community. It was also intended to ascertain, if possible, what the members of your society are thinking concerning the problems faced by the entire profession.

In the matter of emergency and night calls, several of the larger cities have set up a service, either through a local hospital or through a physicians' exchange, whereby the patient is able to obtain medical care. The individual physician takes his turn at night in being on duty, making house calls where the patient cannot be brought to the hospital. The patient may be referred to his family physician in the morning if he so desires. The duty physician may call the surgeon, or other consultation, whenever he thinks it necessary. In our own county, or rather in the city of Elkhart, the E.E.N.T. specialists and the men with serious disability, such as severe heart disease, are the only ones excused from such service. In the smaller communities, of course, such a plan is impossible. It is more or less a case of every man for himself. The individual physician must be governed by his own sense of duty to his patients, always keeping in mind the good will of the public and the propaganda for federal medicine. We can all take a lesson in sense of duty from a fellow secretary, Doctor W. T. Lawson, of Danville, secretary of the Hendricks County Medical Society since 1879, who in spite of his ninety-six years carries on an office practice, and will make night calls, any distance, if called for in a warm car. That is certainly doing one's duty to his fellowmen. It is a real challenge to all of us, youngsters and oldsters alike.

Relative to what is being done and what is being considered about insurance schemes, both federal and state, the majority favored the plan now under consideration and study by the Indiana State Medical Association. There were a number of societies that were just sitting tight. There were a few societies which were emphatically opposed to the plan being studied by the Indiana State Medical Association. As for federal schemes, the sentiment was one of whole-hearted opposition. Some societies are conducting an active speaking and propaganda campaign against these schemes, while in other societies the attitude seemed to be, "Let George do it," or "It can't happen here."

Gentlemen, it is the responsibility of each individual physician to acquaint himself carefully and dispassionately with all those proposals that have been offered, and with those that will be offered. We must be certain that the economics of medicine, involving the payment or pre-payment for medical care, is absolutely divorced from the professional side of medicine, dealing with diagnosis and treatment of disease in all aspects. We must keep the latter inviolate.

I commend to your attention for reading and study the Interim Report of The Wartime Health and Education Committee of The United States Senate, which appeared in *The Journal of the American Medical Association* as of January 6, 1945. It is quite comprehensive and may indicate what we are likely to face in the near future. Representative Dingell has revived The Wagner-Murray-Dingell Bill to further plague us. It is a constant threat which must be closely watched to prevent its being passed by some parliamentary trickery.

We must ask ourselves whether our present proposals to answer the threats of federal medicine are sufficient, or are we sending in a boy to do a man's job? Let us be realistic in our planning. The medical profession certainly has the brains, intelligence, and the ability to work this thing out in the manner and to the extent that it should be worked out. I sincerely believe that the public looks to the medical profession for the leadership in this problem rather than to the politician who is intent upon solving all problems by fantastic legislation and limitless amounts of the taxpayer's money. Medicine has a definite program. It is a sound and well-thought-out program. It is based upon the objective of the American medical profession; namely, "availability of medical care of a high quality to every person in the United States." In the January 13, 1945, issue of *The Journal of the American Medical Association*, pages 98 and 99, is an address by John H. Fitzgibbon, of Portland, Oregon. This address was given before the Annual Conference of Secretaries and Editors of Constituent State Medical Associations, in Chicago, last November. It is well worth reading.

In our county public relations activities let us not neglect the slightest opportunity of informing the public about medical problems as they affect the public itself. Our public relations committee should invite all organizations, locally, to confer with us freely in matters concerning medical care. We can thereby mold a great deal of the public opinion to our way of thinking. Mr. Secretary, if

* Presented before the Secretaries' Conference of the Indiana State Medical Association, at Indianapolis, on January 21, 1945.

your county society is anything like the Elkhart County Medical Society, that will be your job. We can make our public relations committees a very effective instrument of good will toward the profession if we try even a little bit to do so.

A few societies send out news bulletins to the physicians from their society who are in military service. These bulletins contain news about the things going on at home, letters from the men in service, and often the addresses of all the men in service. Other societies send out either group or individual letters. Our colleagues in the armed forces enjoy these bulletins and letters very much.

Concerning the meetings of the local societies, most of them make use of outside speakers. Some counties use a combination of local talent and outside speakers. A few societies have very infrequent meetings or no meetings at all. My own society this year has gone back to its regular monthly dinner meeting after meeting every other month for two years. We made this change because we believed there was so much happening all the time that it was impossible to keep up with matters in any other way.

To the question, "Do you have any pet peeves or gripes you want to get off your chest?" there were some interesting answers. Most of you are either pretty well satisfied, or else you have marvelous self-control. The greatest peeve is poor attendance at meetings and lack of interest in the business side of medicine and the county society. The peeves then run the gamut from socialized medicine, welfare reports, getting each physician to do his full share of the work, too many reports to fill out, lay interference in medical practice, and even unto Eleanor. I will quote some of the more outspoken ones, but will not mention the society from which they originated. The following remarks are quotations:

"The indemnity is all wrong. Those who advocated 'Indemnity' and put it over are, no doubt, the same ones who have controlled the policies of the A.M.A. They give a lot of reasons why the indemnity form of insurance is best, but their reasons are very leaky. They will not hold water."

"Failure of last meeting of A.M.A., House of Delegates to replace Fishbein and West. This failure has lost the support of the men in service practically to a man. They place little or no value on A.M.A. membership."

"Just to leave us alone and we will take care of local situations."

"The paternal attitude and hush hush." "Stop your down method of many organization politicians at state meetings."

"We are against the state society entering into the insurance business."

"I cannot see the advisability of taking the state meeting away from a fine teaching center like the medical school. Our meetings should be more clinical, by University teachers and visiting speakers. Why go to French Lick next year? The meetings of the House of Delegates should be held while no scientific session is on. Some of us want to attend both meetings. Is the stag meeting needed longer, or is it doing what is really needed to be done? How about class, fraternity, and other group meetings on this hour instead of stag meeting? Don't misunderstand me."

"So much jealousy in this county that it is very hard to get unified action on any matter."

"To damned much work and too few M.D's."

"While our society has not voted on it recently, many members feel that the age limit for honorary memberships should be reduced to seventy. We have a number of these older men that are right on the job and should be honored. Very few ever make it to seventy-five. This rule will have to be changed at a state meeting. Also, there is considerable growling about the 'take' of the state association. We are getting along very well on the same dues as always, and with sixty-five members in military service not paying. We do it by cutting expenses, so it looks as though the state office could do likewise, so a lot of the boys think."

"We feel that the Indiana State Medical Association and A.M.A. have not represented the everyday 'bag-toting' doctor or the general practitioner. Too many specialists who don't know what it is to look after the sick public, as we do, run these organizations. We feel that one of the chief causes of crying for political or socialized medicine is the high cost of specialists, principally surgery, x-ray, and laboratory. Nobody objects to regular medical or obstetrical fees. The above are out of proportion to what we get for pneumonia, diabetes, etc. Those are the items covered by insurance. There again the patient and his family doctor are 'hooked' for the regular things.

"The Secretaries Conference is rapidly becoming the biggest influence in Indiana Medicine. More powerful and more representative than the Executive Committee or House of Delegates."

"Feel that the Indiana State Medical Association should compose a card-filing system for use by all county societies. These cards are to be for the personal history of each doctor, so that the records of the membership in each local society would be uniform throughout the state."

"There are only six M.D's. in our county. We have all worked more than we should, but the boys in the 1st, 3rd, and 7th are working harder, so we should not kick. It is my opinion that if every one of us will get down to business and forget a lot of these frills and gadgets, and treat the sick and forget about ourselves being overworked, we will get along, and the people will have adequate care. P.S.: It is now midnight, just delivered a boy, and am now waiting for another."

So you can see what some of the other secretaries and societies are thinking about. You may draw your own conclusions.

The reasons given for the men not writing up their interesting cases for the State Journal are as follows: "too busy," "never asked to before," "no writers in group," "apparently not interested in

doing so," "never been invited to do so," and Lake County says, "When Dr. Shanklin cracks the whip, Lake County doctors cooperate and write what he wants written." Maybe Dr. Shanklin should travel around over the state a little more with that whip. If you have any interesting or instructive cases, write them up for your State Journal. It helps you as well as the other fellow. Please do not write just in the hope of seeing your name in print.

To the question, what is the attitude of your members in regard to the National Physicians Committee, the United Public Health League formed by the western states, and the Association of American Physicians and Surgeons, organized by the Lake County Medical Society, the replies were mostly favorable toward the National Physicians Committee, with the Association of American Physicians and Surgeons ranking second. Many had not heard about the United Public Health League. I will quote a few of the more detailed answers. "Not so hot." "We wonder what is in their pants." "None of us are actively in favor of these organizations." "Indifferent." "We have definitely registered against all types and attempts." "Not excited." "Don't think so much of them." "No definite opposition or derogatory remarks, to the best of my knowledge." "Approve of National Physicians Committee, not acquainted with others." "We have supported the National Physicians Committee with two contributions of money, (maybe we are a bunch of fools though)." "Apathetic in general. We hold the opinion that effort and money should be made through the A.M.A." "I would rather not put it in print, some of it sounds bad." "Favorable to N.P.C. Believe other superfluous." "We do not favor such organizations." "More or less indifference. Too many organizations trying to do the same thing." "The doctors here are for organized medicine." "Should be unnecessary." "There are so many, and we have no way of getting authoritative information; we just do nothing." "National Physicians Committee has been supported by this society, and their pamphlets combating the Wagner-Murray-Dingell Bill have been distributed by the physicians of this county to their patients." "We believe in Free America, and that people should care for themselves." "Take no interest whatever in such. They trust the A.M.A. and our state association." "Much talk, no action. Why isn't there a continuance of active newspaper, magazine, and radio campaign? Our physicians are tired of receiving voluminous literature from the N.P.C. propagandizing us! We don't need to be sold! We're 'agin' the socialized scheme! Why isn't the time and money spent in carrying the message to those who need it? We favor 'down to earth' realism, hard cash politicians who produce results, lobbyists, if that is what it takes, openly and with some money to spend, working for us. No amateurs, please!" "Most of our members have contributed to the N.P.C.; our treasurer usually requests a contribution each time the N.P.C. needs more money. Some have joined the Association of American Physicians and Surgeons. There is no common opinion except dissatisfaction with the A.M.A." And from Lake County is this reply: "Our members believe that the National Physicians Committee has done a good propaganda job that should have been done by the A.M.A. The N.P.C., however, cannot achieve the objectives of either the United Public Health League or the Association of American Physicians and Surgeons, because the rank and file of physicians have nothing to do with its policies or conduct, and it cannot, therefore, represent them. The National Physicians Committee is a propaganda agency only.

"The United Public Health League has as its single objective the influencing of legislation, for all practical purposes.

"When the efforts of the above two organizations have failed, as many believe they may, the only method of preventing the regimentation of the medical profession in the face of legislation creating compulsory insurance is that of a refusal of physicians to participate in such schemes. When a majority of physicians have become members of the Association of American Physicians and Surgeons, and have thereby contracted and agreed with each other that they will remain free practitioners of their profession, there can be no bureaucratic regimentation of medicine.

"We see no conflict between these organizations and the A.M.A., and our members support them all. They believe it wise to go into battle with all the weapons of war."

Do you wonder that my head is in a whirl after trying to draw real conclusions from all these divergent answers? Anyhow, it seems that in reply to the next question, that except for a few counties the "take" of the National Physicians Committee is the greater, and chiefly from the individual physician.

The majority of answers to the final question, "Do you feel that the American Medical Association should be doing the work these organizations have been formed to do?" were in favor of the A.M.A. doing this work. There arises the question whether such activity would permit Mr. Morganthau to get his hands pretty deep in the pockets of the A.M.A. treasurer, if such activities were carried out. There was a surprising amount of criticism against the present leadership of the A.M.A., and in talking to individual members of my own society I find quite a bit of criticism of the same sort.

We must ask ourselves whether such criticism of this leadership is justified. After all, it is you and I and all the rest of us that make up the American Medical Association. We must ask ourselves whether our representation is all that it should be. Is the American Medical Association a democratic organization, or is it controlled by a medical aristocracy? Should the county societies receive advance notice of matters to come before the House of Delegates of both the Indiana State Medical Association and the American Medical Association, so we may study the problems and indicate to our

duly elected delegates the wishes of our individual societies? How often do we have contact with the counsellors of our respective districts? Do they know the temper of the members of each component county medical society? These and others are the questions we must ask ourselves. We must work toward harmony and confidence within our own ranks if we are to repel the attacks upon the profession.

Gentlemen, it has been a lot of hard work getting this report together, but I feel that I know you all better, and so it has been worth the effort. I would like to close with a little quotation attributed to Admiral Hart in "Where Away," taken from January issue of the *Readers Digest.*

"Dear God, give us strength to accept with serenity the things that cannot be changed. Give us courage to change the things that can and should be changed. And give us wisdom to distinguish one from the other."

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## NAVY DOCTORS—AND THE TYPES OF DUTIES TO WHICH THEY ARE ASSIGNED

Now, for the first time, a categorical description of the principal duties of medical officers in the United States Navy has been prepared. Although the Navy cannot promise a candidate his exact preference for duty, it makes every effort to place him where he can work most effectively. This applies particularly to doctors who have had special training, for the value of placing specialists on duty where they can best use their experience is clearly recognized.

The possible assignments to Naval medical officers are divided into five categories. Outlines of these duties follow:

1. *With the Marine Corps*: On an invasion a doctor assigned to this duty is with the front line, as a rule going in with the third or fourth wave. The duty of this officer is comparable to that of an Army combat doctor. He works in the field.

On Marine duty the naval doctor may be assigned to a field hospital in Marine divisions in which all major surgery is initially done on the wounded. The doctors in these hospitals have an opportunity to do more real surgical work than those stationed in major rear base hospitals. They are called upon to use great imagination and initiative. During the initial physical phases of landing, all serious cases are evacuated to transports and hospital ships for surgery. After sufficient beachhead has been established, field hospitals are set up.

2. *Aboard a Destroyer*: There are 149 to 325 officers and men assigned to duty on a destroyer, depending upon the size of the ship. Usually one medical officer is assigned to a destroyer, and he has charge of all medical material and stores aboard, and the treatment and care of the sick and wounded. He also functions as a sanitation and health officer by advising the commanding officer in matters pertaining to the proper care of food and water and the general hygienic condition of the ship itself.

The medical officer's professional duties are similar to those of the general practitioner in a small community, with emphasis on the preventive aspects of medical practice. Indeed, a destroyer is a small community in itself, and the medical officer enjoys the same respect and prestige from the crew as he does in civilian life.

3. *Aboard Large Ships (Battleships, Cruisers, Carriers)*: The normal complement of a battleship is 1,750 to 2,600 officers and men; a cruiser, depending on whether it is light or heavy, from 700 to 1,550 officers and men; an aircraft carrier from 2,800 to 3,500 officers and men.

Three to five medical officers are assigned to the larger ships. The senior medical officer is responsible to the commanding officer, in the same way as the destroyer medical officer described above, for the medical supplies and equipment, and in an advisory capacity on matters of hygiene. The care of the sick and wounded is a greater problem, of course, but is facilitated by the larger sick-bay space and elaborate equipment, such as operating tables, x-ray machines, pharmacy, laboratory, et cetera. These large, air-conditioned spaces which make up the sick bay of the modern super dreadnaughts are small hospitals and function as such in every way. All types of surgical cases and illness are treated here.

The medical officers of these large ships also act in a consultant capacity to smaller vessels. In isolated ports destroyer sailors come aboard for blood tests, x-ray examinations, treatment of fractures, and for surgical operations.

4. *On an Advance or Rear Base, on a Hospital Ship, or in a Hospital in the United States*: A doctor functions in any one of these assignments in the same way as he would when practicing general medicine and surgery, or as a specialist in a large city. He has the finest equipment available to him. He works and consults with associates in the same way as he does in civilian life.

Specialists are usually assigned to shore and hospital ships in order to take advantage of their skills. For example: at the Naval Medical Center at Bethesda, Maryland, there are specialists in orthopedics, neurosurgery, tropical diseases, chest surgery, and internal medicine—indeed, all the professional specialties.

5. *Assignment to Medical Research*: Laboratory research, under the cognizance of the Bureau of Medicine and Surgery, follows in general the same line as that of important research centers in civilian medicine, but is channeled according to military interests and with military application in view.

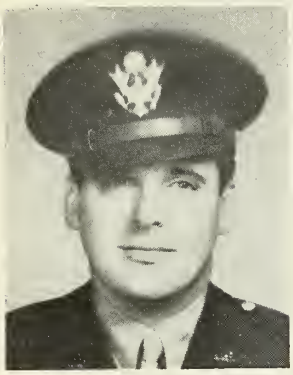
Naval research laboratories are constantly working on ways to improve service to the fleet, and to the advance and rear base hospitals. The use of plasma, Penicillin, the latest drugs, new methods in the treatment of burns, and the changing problems in war wounds are all under the continuous scrutiny of the naval research centers.

The Navy's need for doctors in all of these types of duty is still very acute, and every eligible doctor is needed now. Doctors previously declared physically disqualified are being reconsidered in view of a modification of physical requirements. Such doctors are urged to contact Lieutenant R. F. Crawford, of the Navy's Medical Corps, at the Office of Naval Officer Procurement, 141 W. Jackson Boulevard, Chicago, WABash 2900, in order to make an appointment for physical examination to ascertain whether or not they are qualified.

Doctors up to sixty years of age are now being considered by the Navy. Complete information may be obtained from Dr. Crawford. The doctor's tasks in the Navy are clear and concise. The need for men to fill these assignments is critical.

# Military News

Now that the war is ended in the European theatre, we will gradually see our men drifting back—some will go on to the Southwest Pacific, others will continue in the service of Uncle Sam in the United States, and others will, of course, be returned to private practice.



*Major Donald E. Wood*

Major Donald E. Wood, of Indianapolis, was one of the first ones to be returned, arriving here in January of this year, and is now serving with the Induction Center at Indianapolis.

Major Wood entered Camp Bowie, Texas, in March, 1943, with Indiana General Hospital No. 32, which embarked for its destination in September, 1943, and he later became its executive officer. He has been with the hospital unit throughout its European expeditions, which was first located near Oxford, England, then following D-day moved into Normandy, being stationed near La Haye Du Puit, later being moved to Liege, Belgium, and finally became established at Aachen, Germany, where it is now giving unprecedented service in caring for the thousands who must be hospitalized pending their transfer to the United States or to other quarters.

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Dr. Frederick D. Cheney, of Indianapolis, has been promoted to a lieutenant colonel. Colonel Cheney is chief of medical service with the Indiana General Hospital.

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Congratulations to Dr. James C. Brown, of Valparaiso, who has recently been awarded his majority. Major Brown is on duty with a field hospital in Belgium.

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Captain Kile C. Hardesty, of Fort Wayne, has gone overseas with an engineering combat battalion. He was formerly stationed with a bomb group at Avon Park, Florida.

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Captain Kenneth L. Shaffer, of Vincennes, who has been stationed at Miami, is now on duty at the Percy Jones General and Convalescent Hospital, at Battle Creek, Michigan.

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Captain L. T. Kudele, of Whiting, has been transferred from the Percy Jones General and Convalescent Hospital, in Battle Creek, Michigan, to the Wakeman General Hospital, Camp Atterbury, Indiana.

Previously in New Guinea, Major George Plain, of South Bend, has been transferred to the Netherlands East Indies.

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Now on duty with a station hospital in the South Pacific, Dr. W. T. Cox, of Lafayette, has been promoted to a major. Congratulations, Major Cox!

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Major William H. Clark, of South Bend, has been transferred from Clovis, New Mexico, to the air station hospital at Alamogordo, New Mexico.

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Two Indiana physicians serving with a division on Bataan are Lieutenant Colonel Frank B. Ramsey and Lieutenant Colonel Robert D. Howell. Colonel Howell is in command of a medical battalion, and Colonel Ramsey is division surgeon.

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Major M. Cornacchione, of Indianapolis, has recently been transferred to the Percy Jones General and Convalescent Hospital, at Battle Creek, Michigan. He was formerly stationed at Baer Field, Fort Wayne.

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Another Indiana doctor, Major Herbert H. Inlow, of Shelbyville, has been decorated. He was awarded the Legion of Merit for "exceptionally meritorious conduct in the performance of outstanding services in Sicily, Italy, and Southern France, as chief of the radiology section of an evacuation hospital." Major Inlow is now stationed in France.

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After returning from the Southwest Pacific, Major Albert L. Marshall, of Indianapolis, has been confined to a hospital at Miami Beach, Florida, with malaria. He seems quite optimistic, saying that although no one likes to have malaria, he at least had comfortable accommodations at the Nautilus, a luxurious resort hotel taken over by the Army for a hospital.

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From somewhere at sea, Major George R. Dillinger, of French Lick, writes: "At present it looks as if I am getting into some active service. At least when I return I will be able to tell some travel tales. Keep me posted as to what is going on, for it is unlikely that I will be present for any meetings this year." Major Dillinger has a San Francisco A.P.O. address.

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Major John W. Little, Jr., of Indianapolis, is now on duty with an evacuation hospital. He was the first commissioned man to report for the development of this particular hospital, having served in England, France, and now somewhere in Belgium. While in France, Major Little was deeply impressed with the havoc and evidence of ruthlessness that have resulted in three years of this kind of warfare, and his observation was, "I am sure that we should re-read the headlines."

Dr. Richard A. Ganser, of Mishawaka, is at present based ashore in the Aleutians. Outside of the usual casualties, they see a great deal of sprains and persistent myositis.

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Lieutenant Wyndham N. Nutter, of Rushville, has gone overseas with a general hospital. He was formerly at Fort Benning, Georgia.

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Captain James M. McFadden, of Fort Wayne, has been transferred from the Crile General Hospital, at Cleveland, Ohio, to a medical laboratory at Fort Lewis, Washington.

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We were pleased to hear that Dr. Robert M. Hansell, of Indianapolis, has been promoted to a captain. Captain Hansell is on duty with a general hospital located in England.

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Major Leonard C. Lund, of Argos, has been evacuated from Bougainville for medical reasons, and is now on duty with the station hospital at Camp Howze, Texas.

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Recently introduced to the Navy, and now stationed at the Great Lakes Naval Training Center, is Dr. J. L. Emenhiser. Doctor Emenhiser entered service on March fifth.

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Captain J. R. Matthew, of Knox, is home on a leave, and is recuperating from injuries received while serving with the American forces invading Europe.

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Captain Jesse R. Logan, of Evansville, has been transferred from the Nichols General Hospital, in Louisville, Kentucky, to a station hospital at Fort Story, Virginia.

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Major Kenneth B. Fisher, of South Bend, and Captain Jacob Rosenwasser, of Mishawaka, are now at Fort Oglethorpe, Georgia, and, along with other doctors, must during the next four months train seven thousand WACs as medical and surgical technicians.

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After three years' service overseas, Major Basil M. Merrell, of Brownstown, has returned to the United States. Stationed overseas with a medical unit at a station hospital, Major Merrell was in Iran one year and went from there to India.

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Captain O. Raymond Russell, of Frankton, has been awarded the third Oak Leaf Cluster to the Distinguished Unit Badge, now that the unit of which he is flight surgeon, a veteran P-47 Thunderbolt air support outfit, has become the first American Air Force unit in the Mediterranean theater to be cited four times in War Department general orders.

Formerly with a hospital train, Major Frederick W. Buechner, of South Bend, was injured in December, and is now hospitalized at Billings General Hospital, at Fort Benjamin Harrison, Indiana.

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Billings General Hospital soon will get a new surgery installation as the result of a War Department authorization. No increase in bed capacity is included.

Provision of covered walkways between wards and mess halls at the Wakeman General Hospital, at Camp Atterbury, Indiana, also has been authorized by the War Department.

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Although he didn't state his new location, Captain Morris E. Thomas, of Indianapolis, writes that "it is a much cooler place than Guadalcanal." He goes on to say, "I just arrived here a few days ago. There are a few Nips left, but they cause very little trouble. So far there seems to be a scarcity of Hoosiers here."

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We have received a letter from Major William W. Washburn, of Lafayette, now stationed on Corsica, who writes: "I have an aviation medical dispensary, and have been here in Corsica for almost a year. It has been grand this winter, almost like Florida as far as the weather is concerned, although I cannot say too much for anything else. These dispensaries are independent organizations, with twenty-four enlisted men and four officers, and sufficient equipment to take care of thirty-six cases. We have x-ray and laboratory equipment, so we can practice some medicine, but the administrative end of it sure is a headache."

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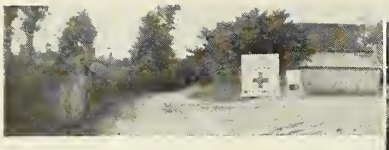
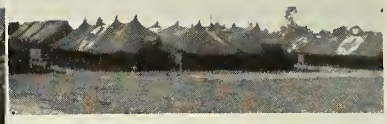
Major Gordon H. Haggard, of Hope, who has been missing in action since October seventh, has been awarded the Legion of Merit for his service as medical inspector of the 76th Division at Fort Meade, Maryland, from July to October, 1942. The award was presented to his son, Cadet Gordon M. Haggard, who is a student at the Kemper Military School.

Major Haggard's invention and original construction of models of war wounds was used in the production of bandages adopted by the Army for use as a standard item of issue. Not only have they simplified First Aid training, but have increased the efficiency of Army personnel in the application of medical aid.

According to the last word received in this office, Major Haggard was a prisoner of the Nazis after a flight over Germany. At the time of his capture, Major Haggard was serving as a flight surgeon with a B-17 Flying Fortress group. He also holds the Air Medal for meritorious service. With the changed status in Germany, we are hoping that Major Haggard will soon be back with us.



*Main entrance to the hospital while located in Normandy.*



*Receiving ward tents, side-laced in threes.*

# INDIANA GENERAL HOSPITAL No. 32

On May 13, 1942, a momentous occasion took place on the campus of the Indiana University Medical Center—that of the commissioning ceremony of General Hospital No. 32. On that day the valient members of a unit organized by the Medical Department of the Indiana University Medical Center marched to the platform, to the stirring strains of martial music played by the R.O.T.C. Band of Indiana University, raised their right hand and took the oath of allegiance as members of the armed forces of the United States of America.

Although a thrill went over the vast assemblage which had gathered, flanked on every side by men from the Medical Corps, war clouds hung heavily over the entire group. But, come what may, everyone knew that General Hospital No. 32 would carry out the hopes of the state and nation. That hope has been fulfilled, for today this hospital unit is operating in Germany. Because of its accomplishments it was one of the first to go into Normandy last July, and when Germany was invaded it became the first and probably the only general hospital which entered Germany.

Following its induction the unit waited impatiently month after month for word to move. Finally, the following March the unit in its entirety entered Camp Bowie, Texas, where the next six months were devoted to training. An enlisted personnel of five hundred men joined the unit at Camp Bowie, and these GI's were also trained in the manner in which the hospital was expected to operate. Next they were on their way rejoicing, with Lieutenant Colonel Cyrus J. Clark, of Indianapolis, as Chief of the Medical Service; Lieutenant Colonel Charles F. Thompson, of Indianapolis, as Chief of the Surgical Service. In England they did good work, and were recognized for it. Little was heard of the unit for a time, but as one member put it, "they were so busy that publicity became a hazard."

*Major Steele seems to assume that a chowhound's mascot is his mess kit.*

*This is the field in which the hospital was located when the unit first arrived in France.*

Early in 1944 Colonel C. J. Clark became the commanding officer of the entire unit. Prior to that time the unit had been under the command of a regular Army officer, Lieutenant Colonel Frank O. Alexander, of Washington, D.C. Major Donald E. Wood, of Indianapolis, became executive officer.

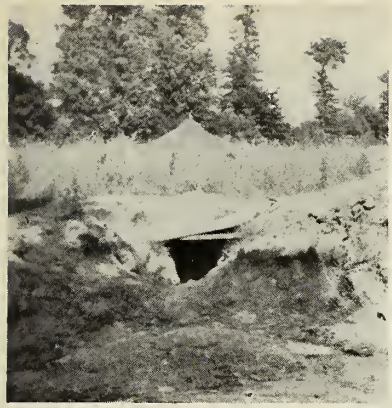
*"We're in the Army now!"*

*Left to right: Major Engle, Captain Mantz, Captain Oliphant, Captain Garber.*

Major Wood has returned to Indianapolis, and has given a firsthand account of some of the experiences, as well as supplied us with photographs of this unit. We quote:

"The history of the medical units serving in the ETO will be outstanding because of their superior record of achievement from the front-line aid station to the rear echelon general hospital unit. Much of the credit is due to the far-seeing vision and leadership of the Chief Surgeon, Major General Paul R. Hawley. All of the doctors, nurses, administrative officers and corpsmen also deserve their just praise. The doctors of Indiana will be justly proud of their colleagues, those who have served in this theatre as well as all the theatres of war, when the final history of the medical service is written.

"The Thirty-second General Hospital is proud to have been part of the tremendous undertaking. During the past two years it has moved steadily forward, and I can say without hesitation that it has been among the top medical units in the ETO. Lieutenant General John Lee, in a letter to General



*Yes, they had foxholes, too.*

Hawley, in turn to Colonel C. J. Clark, commended the unit upon its performance in England.

"During our stay in England prior to D-Day the hospital was housed in the Nissen type huts. This was most comfortable. The over-all setup required some sixty-three acres. There were thirty-three wards, each capable of a thirty-bed capacity, and one small isolation ward to round out the one thousand beds. There were ample clinic buildings. The operating theater was well equipped, as were the laboratory and x-ray departments. The personnel quarters were better than we had anticipated, but the recreational facilities were limited.

"Our patients consisted of the combat men who were injured during the long training period, or some medical problem. We had only one minor respiratory epidemic. These were cases of influenza, atypical pneumonia, and coryza.

"Following our arrival in France the unit was split up into surgical and shock teams which for short periods were sent out to the various field and evacuation hospitals to relieve the overworked assigned personnel. It was here that the doctors and nurses got their baptism under fire. They operated or treated shock on twelve-hour shifts, and were busy during the entire period doing everything from debridement to major surgery, and the giving of plasma and whole blood and general supportive therapy. It was an exhilarating feeling, and one that we had longed for. After a few weeks of such work our own tented hospital was ready for occupancy, and the work continued. The equipment was superb, even the surgeons could not complain. Amputations, secondary closures, and fracture work of all types predominated. We had our share of "Krauts," too. Toward the end of three months, having trained other general hospital units in administration technique, and simultaneously operating our hospital, we again were moved into the forward area. We left the tents and all of our equipment with the unit taking over the hospital. Moving is a tremendous undertaking, and the administrative difficulties are manifold.

*"Oh bed! O bed! delicious bed!*
*That heaven upon earth to the weary head!"*

*Left to right: Major Pell, Major Hippensteel, and Major Mahoney.*

"The hospital moved into permanent buildings in Germany, and they now have a fine modern hospital. Their activities have, of course, paralleled those in Normandy.

"Colonel Clark has had the chiefs of services compile their records, so I am sure that a more exact accounting and efficient report will be forthcoming concerning their medical activities in the ETO.

"The unit is still in Germany, and was probably the only, or at least one of the very few, general hospital

*Left to Right:*

*1. Chaplain's office.*

*2. Hospital chapel at Normandy, including the triptych presented to the hospital by Dr. and Mrs. G. H. A. Clowes.*

*3. Special service tents, containing radios, books, et cetera.*

*No tile bath for Colonel Clark, so he's on his way to the outdoor shower.*

*Colonel Thompson was not to be outdone; he improvised his own boudoir.*

*Top: Hospital power plant.*
*Below: Shower tents and pumping facilities.*

units to operate in Germany. The questions that filled the mind of all of us when we entered active duty—'Where will we go, and how long will we be in?'—again confronts them. The only answer of which they can be sure is, '*We're in the Army now.*'"

The original unit consisted of fifty-seven officers, of which fifty were from Indianapolis; one hundred nurses, three dieticians, two physiotherapists, five Red Cross workers and five hundred enlisted men, ninety of whom were also from Indianapolis. Seventy-two of the original staff of nurses still are with the unit. Major Aurelia Willers, the original commanding officer of nurses, still holds that post.

Much of the original unit is still intact, but because these specially-trained men looked good in advanced positions in other units, the Army Medical Corps raided the staff shortly after its arrival in England. The physicians still with the unit are Colonel Cyrus J. Clark, of Indianapolis, the commanding officer; Lieutenant Colonel Frederick D. Cheney, of Indianapolis, Chief of Medical Service; Lieutenant Charles F. Thompson, of Indianapolis, Chief of Surgical Service; Lieutenant Colonel Carl S. Culbertson, of South Bend, Chief of Laboratory Service; Lieutenant Colonel Charles F. Ingersoll, of Grand Rapids, Michigan, Chief of X-Ray Service; and Major Charles A. Everett, of Indianapolis, Chief of Dental Service.

Others in the Surgical Service are Major L. S. McKeeman, of Fort Wayne; Major Robert L. Amos, of New Castle; Major Howard D. Cogswell, of Whiting; Captain Dallas Fickas, of Evansville; Captain John R. Haslem, of Terre Haute; Captain Theodore P. Mantz, of Indianapolis; Captain Robert W. Oliphant, of Terre Haute; and Captain Samuel Simon, of New York City.

With the Medical Service are Major Russell R. Hippensteel, of Indianapolis; Major Brandt F. Steele, Indianapolis; Major David E. Engle, of Elmhurst, Illinois; Major William D. Gambill, of Indianapolis.

Major Charles L. Mahoney, of Terre Haute, is on Ear, Nose, and Throat Service, and Captain Otto L. Siewert, of Logansport, is on Eye Service. Captain J. Neill Garber, of Indianapolis, is on Orthopedic Service; Captain William H. Lane, of South Bend, is on Anesthetic Service; and Captain William B. Rossman, of Indianapolis, is on Psychiatric Service. Captain William F. Hanning and Captain Frank W. Jordan, both of Indianapolis, are with the Dental Service.

The following physicians who were formerly with the hospital have been transferred to key positions in other hospitals: Lieutenant Colonel Paul G. Iske, of Indianapolis; Lieutenant Colonel Paul J. Fouts, of Indianapolis; Captain A. Ebner Blatt, of Indianapolis; Lieutenant Colonel Isadore Kwitny, of Indianapolis; Lieutenant Colonel James M. Leffel, of Indianapolis; Lieutenant Colonel Dennis Megenhardt, of Indianapolis; Lieutenant Colonel Jack E. Pilcher, of Indianapolis; Major Fred C. Reynolds, of Indianapolis; Major J. S. Browning, of Indianapolis; Major William H. Norman, of Indianapolis; Captain Donald F. Caseley, of Indianapolis; Captain John H. Smith, of Bloomington; Captain Robert C. Speas, of Bloomington; Captain G. H. A. Clowes, of Indianapolis; Captain George D. Davis, of Indianapolis, and Captain James N. Topolgus, of Bloomington.

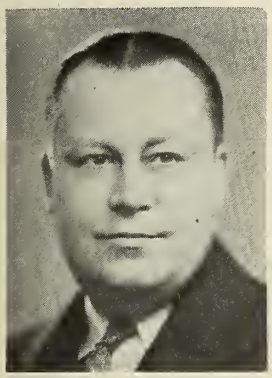
Major Donald E. Wood, of Indianapolis, and Captain James E. Engeler, of Indianapolis, have been returned to this country, and are now on duty in the United States.

Major James F. Balch, and Major Glen Pell have returned to private practice in Indianapolis.

General Hospital No. 32 is now stationed at Aachen, where it plunged into its biggest task to date, the hospitalization and treatment of patients, plus screening those troops for return to the U.S.A. and to other theatres of operation.

# News Notes

Ray E. Smith who has been appointed to serve as executive secretary of the Indianapolis Medical Society will also serve as an assistant to Thomas A. Hendricks at the state headquarters' office. Mr. Smith will begin his duties on June first.



*Ray E. Smith*

Ray E. Smith was born at Huntington, Indiana, on June 29, 1897. After his graduation from DePauw University, Greencastle, in 1921, he became a reporter for *The Franklin Evening Star*. He served as city editor of *The LaPorte Argus*, and managing editor of *The La Porte Herald - Argus*, leaving the field of journalism in 1929 to become advertising manager of the LaPorte Metal Door and Trim Company, now known as the LaPorte Corporation.

In the summer of 1932, Mr. Smith re-entered newspaper work as managing editor of *The Michigan City Evening Dispatch*, resigning this position in February, 1934, to assume the editorship of *The Hoosier Sentinel* in Indianapolis.

When former Governor Henry F. Schricker took office in January, 1941, he appointed Mr. Smith as his penal affairs secretary. In October of the same year Governor Schricker named him as his executive secretary, to succeed Edwin A. Wilkins, who died.

He was appointed to the State Board of Tax Commissioners by Governor Gates on January twelfth of this year.

Mr. Smith is a member of the North Methodist church; Masonic Order; Elks Lodge; Phi Delta Theta, college social fraternity; Sigma Delta Chi, journalism fraternity, and the Indianapolis Press Club. He is a past president of the Indianapolis DePauw Alumni Club and the Indianapolis Alumni Club of Phi Delta Theta.

**A.M.A. MEETING BANNED**

"War Committee on Conventions of Office of Defense Transportation in Washington has denied permission for meeting of the House of Delegates of the American Medical Association in July. Will attempt to secure permission for a meeting of the House at a later time. Please notify delegates to the American Medical Association of your association."

OLIN WEST,
*Secretary and General Manager.*

Dr. Leon Levi, of Indianapolis, has returned from service, and is reopening his office at 40 West Thirty-eighth Street.

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Dr. Gordon W. Batman, of Indianapolis, has been named as president of the Marion County Tuberculosis Association. He was elected at a meeting of the Board of Directors on May first.

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The degree of Doctor of Science was conferred upon Dr. Herbert F. Thurston, of Indianapolis, at the Franklin College commencement, held at Franklin on May sixth.

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Donald W. Brodie, M.D., has received a medical discharge from the Army Medical Corps, and is opening an office for the practice of medicine at 817 Chamber of Commerce Building, in Indianapolis.

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On April fifteenth a $220,000 addition to the Gary Methodist Hospital facilities for student nurses was dedicated by Bishop Titus Lowe, of Indianapolis. Completion of the four-story wing provides housing accommodations for eighty cadet nurses, releasing their former quarters for the use of additional patients.

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Dr. Henry W. Griest, of Monticello, recently celebrated his fifty-first anniversary in the practice of medicine. Most of that time was spent in Monticello, but he served as director of the Presbyterian Hospital, at Point Barrow, Alaska, for seventeen years.

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The annual convention of the Indiana Society of X-ray Technicians was held April fifteenth at the Oliver Hotel, in South Bend. In addition to a program of scientific discussions, there was a luncheon honoring Dr. Stanley A. Clark, of South Bend.

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Dr. Sumner A. Furniss, of Indianapolis, has been appointed as one of the five members of the new Board of Health and Hospitals. The new board, created by the recent General Assembly, merges the former City Health Board with the charities and hospital boards.

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Dr. M. C. Pitkin, who has been with the medical department at the Home Lawn Sanitarium, in Martinsville, for many years, has been elected by the Board of Directors to succeed the late Dr. R. H. Egbert, as medical director. Dr. Jay Harold Grimes, formerly of Danville, has been named as associate medical director.

It has been announced that Dr. Leroy E. Burney, recently of the United States Public Health Service, will become the State Health Commissioner for Indiana on July first. Dr. Thurman B. Rice, who has served as Acting State Health Commissioner since 1942, wished to be released from those duties, and Doctor Burney will at that time take his place.

*Dr. Leroy E. Burney*

Doctor Burney is a resident of Indiana, and a graduate of Technical High School in Indianapolis as of the Class of 1924. He had his college training at Butler University, and received his M.D. degree at Indiana University in 1930. After serving his internship he took one year of Public Health Training at Johns Hopkins University, 1931 to 1932, since which time he has been in the United States Public Health Service and had obtained the rank of medical director, which is equivalent to the rank of colonel in the United States Army, or captain in the Navy. Recently he has been serving as director of District No. 4 of the United States Public Health Service, with headquarters in New Orleans.

He is a member of the American Public Health Association, the American Medical Association, and an Associate Fellow of the American College of Physicians. He has had wide experience in health work and is familiar with the problems confronting the central states; hence, is well qualified for the job.

We welcome Doctor Burney to Indiana, and extend our best wishes to him in his new undertaking.

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Dr. O. Floyd Rogers, Jr., of Bloomington, has been named as the Monroe County jail physician by the board of county commissioners. His term in this capacity will continue until December 31, 1945.

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### AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY EXAMINATIONS

The general oral and pathology examinations (Part II) for all candidates will be conducted at Atlantic City, New Jersey, by the entire Board from Wednesday, June 13, through Tuesday, June 19, 1945. The Hotel Shelburne in Atlantic City will be the headquarters for the Board.

Applications are now being received for the 1946 examinations. For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

Dr. Robert L. Stewart, of Sullivan, who recently graduated from the Indiana University School of Medicine, is now serving a nine-months' internship at the Gorgas Memorial Hospital, at Ancon, Panama.

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Dr. Oran A. Province, of Franklin, was recently honored with a Golden Legion Certificate, emblematic of fifty years membership, presented at the annual Founder's Day banquet of the Phi Delta Theta. He was initiated at Franklin in 1895.

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Dr. Lewis C. Rentschler, of Clay City, who recently suffered a heart attack while en route to Laredo, Texas, was brought to St. Louis from a hospital in Houston, Texas, by plane, and was met there by an ambulance which took him to his home. Doctor Rentschler has improved, but will be confined to his bed for several weeks.

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### AMERICAN COLLEGE OF CHEST PHYSICIANS EXAMINATIONS

The Board of Examiners of the American College of Chest Physicians announce that the next written examination for Fellowship will be held at Chicago, June sixteenth. Candidates for Fellowship in the College who plan on taking the examination should contact Murray Kornfeld, executive secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

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### INDIANA ASSOCIATION OF THE HISTORY OF MEDICINE

The spring meeting of the Indiana Association of the History of Medicine was held at the home of Mrs. Anthony Russo, of Indianapolis, on Saturday evening, May twelfth. Those in attendance at this meeting had a real treat, for the feature of the evening was a talk by Miss Madge E. Pickard, of the History Department of Indiana University, co-author of "The Midwest Pioneer—His Ills, Cures, and Doctors," who presented a most interesting treatise on this book.

This volume, comprising three hundred forty pages, beautifully compiled, is the by-product of more extensive work in the field of pioneer medicine undertaken by Madge E. Pickard and R. Carlyle Buley, of Indiana University. It deals chiefly with the first half of the Nineteenth Century, and covers mainly the Middle West—Indiana, Ohio, Illinois, Michigan, and Wisconsin, with some data from states allied with this territory, namely, Kentucky, Iowa, and Missouri. That the authors had "fun with medical history," as Miss Pickard put it, was quite evident, and those present also became fascinated with the lore from which these authors have compiled this medical history.

Miss Pickard explained some of the various

systems promulged and practiced during the pioneer days—Thomsonianism, Botanico-Medicalism, Eclecticism, Homeopathy, and quackery of every description which successfully competed with the regulars. She also called attention to the fact that although the pioneer country doctor reaped not only the bitter fruits of his bleeding, blistering, and purging practices, but was feared, loved and revered by his clientele.

This is, indeed, medical history, and Indiana is proud of its authors, and to have been the setting for the compilation of a volume so informative as well as attractive.

A short business meeting was held. Mrs. Dorothy Russo, bibliographer with the Indiana Historical Society, was elected president of the association; Miss Grace Bartle, record librarian at St. Vincent's Hospital, was elected vice-president; and Miss Nella H. Rokke, assistant editor of THE JOURNAL of the Indiana State Medical Association, was re-elected secretary and treasurer.

## INDIANA UNIVERSITY NEWS NOTES

Two members of the faculty of the Indiana University School of Medicine and two alumni of the University are included in the five members of the Indiana Council for Mental Health, whose appointments have been announced by Governor Ralph F. Gates.

The members of the Council, which was created by the 1945 General Assembly, will include Drs. LaRue D. Carter, professor of Neurology, and Thurman B. Rice, chairman of the Department of Bacteriology and Public Health, Indiana University School of Medicine; Dr. Norman M. Beatty, of Indianapolis, who graduated from the University in 1927, and Judge John H. Morris, of New Castle, who was graduated with an A.B. degree in history in 1912. Doctor Rice will serve as an ex-officio member of the Council in his office as acting secretary of the State Board of Health.

The council under the legislative enactment will be charged with the construction, on the campus of the Indiana University Medical Center at Indianapolis, of a mental hospital and clinic, for which the General Assembly made an appropriation of $250,000 and allocated $75,000 additional if necessary. This hospital, under the act, will be made available for instruction of medical students, student nurses, interns and resident physicians, under the supervision of the faculty of the University's School of Medicine.

The legislation creating the council provides that the agency shall have authority to transfer psychiatric patients in state hospitals from one institution to another, or to the so-called "screening hospital" on the Indiana University Medical Center campus. Admission to the new hospital also will be open to voluntary applicants, on recommendation of attending physicians.

The new state act is regarded in many quarters as one of the most important passed by the last legislature. It was introduced by Senator Von A. Eichhorn, of Uniondale, and had the support of the Indiana State Medical Association.

# Deaths

**Thomas Martin Smith, M.D.**, of Jeffersonville, died at his home on March twenty-ninth. He was sixty-two years of age. Doctor Smith was a graduate of the Hospital College of Medicine, in Louisville, in 1906.

**Rudolphus W. Fuller, M.D.**, of Anderson, died at Grand Rapids, Michigan, on April twenty-ninth. He was fifty-eight years of age. Doctor Fuller graduated from the Wayne University College of Medicine, in Detroit, with the class of 1909. He was a member of the Madison County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

**Frederick J. Freshley, M.D.**, of Evansville, died April eighth at the age of sixty. He was a graduate of the University of Louisville School of Medicine, in 1908.

**John A. Garrettson, M.D.**, of Indianapolis, died at his home on April twentieth. He was sixty-six years of age. A graduate of the Medical College of Indiana, in Indianapolis, in 1904, Doctor Garrettson practiced in Indianapolis for forty years as an otolaryngologist before his retirement in 1943. He served as a medical officer in World War I, and was clinical instructor at the Indiana University Medical School for fifteen years. Doctor Garrettson was a member of the Indianapolis (Marion) County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION

### EXECUTIVE COMMITTEE

February 11, 1945

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; N. K. Forster, M.D.; J. E. Ferrell, M.D.; F. T. Romberger, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney, and T. A. Hendricks, executive secretary.

This was a streamlined meeting, held to prepare for a special joint meeting, at noon, of the Council, Legislative, and Executive Committees.

#### Budget

The Budget Committee is to meet following the March meeting of the Executive Committee, to make up the 1945 budget.

#### Membership Report

| | |
|---|---|
| Number of members Feb. 11, 1945 | 1981 |
| Number of members Feb. 11, 1944 | 2536 |
| Loss over last year | 555 |
| Number of members Dec. 31, 1944 | 3396 |

#### Treasurer's Office

Dr. Weyerbacher made a report upon the reimbursement of funds to the Medical Defense Fund from THE JOURNAL and the headquarters' office funds. This will be taken care of within the next month.

#### 1945 Annual Session, French Lick, Tuesday, Wednesday, and Thursday, October 2, 3, and 4, 1945

*Commercial Exhibit.* Letter received from the Medical Exhibitors Association, Inc., stating that it desired to cooperate with the ODT order.

Suggestion made that the annual session be devoted to a program of rehabilitation of veterans.

#### Prepayment Medical Plans

Dr. McCaskey made a report upon the Medical Service Plans Council of America.

The statement made by Dr. R. L. Sensenich at the recent meeting of the United States Chamber of Commerce was brought to the attention of the committee.

#### Medical Economics

*The Indiana State Conference on Social Work.* The Executive Committee approved continuation of membership in that organization. Report made that the Conference had obtained the full-time services of an executive secretary, Julian Stone.

The committee approved the continuation of membership in the American Public Health Association.

The committee approved payment of the $10.00 membership fee in the Indiana Inter-Professional Health Council.

The statement of receipts and expenditures in January for THE JOURNAL was approved.

#### Legislative, Legal, and Social Security Matters

*NATIONAL*

Dingell bill, *H. R. 395*, reintroduced in Congress.

The Burton-Hill hospital bill, *S. 191*, which provides $105,000,000 for the construction of hospitals, brought to the attention of the committee. This bill is approved by the American Hospital Association and is approved in principle by the Board of Trustees of the American Medical Association.

*Pepper Interim Committee report.* Third Pepper Interim Committee report brought to the attention of the committee.

The status of accredited schools under the *GI Bill of Rights* reviewed by the committee. Letter received from the office of Clement T. Malan, superintendent of public instruction, giving the list of schools accredited in Indiana under the *GI Bill of Rights.* This is a most important matter as the schools to be accredited for attendance of a veteran who receives funds for his education are passed upon not by the Federal Government but by local educational agencies in each state. In view of the fact that the Palmer School of Chiropractic received a large part of its maintenance funds from veterans whose education was supported by federal funds following World War I, it is doubly important that no repetition of this occurs following World War II. Arrangements are being made by Mr. Malan to have some physician act in an advisory capacity concerning the accrediting of schools having to do with all phases of medicine and public health in Indiana.

*LOCAL*

*Legislative session.* Dr. Norman Beatty and Dr. J. William Wright, co-chairmen of the Legislative Committee, reviewed the major bills which have to do with the public health program.

*Two Association bills. H. B. 143*, modernization of the State Board of Medical Registration and Examination bill, reported as progressing favorably, but it was decided not to press *H. B. 129*, the hospital board bill.

*Osteopathic bill.*

a. Resolutions and letters opposed to the bill, from St. Joseph, Elkhart, Allen, Hamilton, Randolph and several other county medical societies, brought to the attention of the committee. These letters were to be presented at the special legislative meeting of the Council when the osteopathic bill came up for discussion.

b. Letters from the Lake County Medical Society to its representatives, and reports that the Marion County Medical Society had gone on record

(Continued on page xxix)

*(Continued from page 208)*

opposing the bill, brought to the attention of the committee. Dr. Forster made a statement in regard to the opposition of some of the leaders of labor to the bill.

*Cult bills.*

a. Report made that the chiropractic bill, *S. B. 181*, had advanced to third reading, but the committee expressed confidence that this bill would be defeated.

b. Report made also that *H. B. 467*, another chiropractic bill, was reported out of committee.

c. It was also reported that the naturopathic bill, *S. B. 193*, would remain in committee and would not come up for action.

Other bills which were discussed by the committee were the hospital council bill, *H. B. 390;* psychiatric clearing center bill, *S. B. 206*, both of which had received the approval of the Legislative Committee, and *S. B. 3*, which would license men in service without State Board examination, and *H. B. 411*, Riley Hospital part-pay patient bill, which were opposed by the committee.

**Organization Matters**

The Executive Committee discussed the National Physicians' Committee and the American Association of Physicians and Surgeons, originated by the Lake County Medical Society.

Attention of the committee was called to the action taken by the Ohio State Medical Association Council in regard to outside organizations. An excerpt from this statement follows:

"It is the considered opinion of The Council:

"That the American Medical Association is the proper organization to represent the medical profession on legislative, economic and social questions of direct interest to the medical profession, and to handle public relations for the medical profession, in co-operation with the constituent state and component county medical societies;

"That there is no necessity for the formation and maintenance of independent organizations to carry on these activities for the medical profession;

"That the present activities of the Council on Medical Service and Public Relations, and other boards, councils, bureaus and committees of the American Medical Association, as well as of similar agencies of state and local medical societies, demonstrate that medical organization is capable of representing the medical profession;

"That medical organization is capable of carrying on many more productive activities for the benefit of the public and the medical profession alike if the profession will demand complete development of the potential resources, facilities and ability at the command of the American Medical Association and its state and local units, and will give its undivided support to all activities undertaken;

"That it is not the function of the Ohio State Medical Association to say to a member that he shall or shall not affiliate with or support any independent organization which may be soliciting his financial aid. This is a decision which each physician must make for himself. This Association is opposed to regimentation, whether it be within or outside the ranks of the medical profession.

"However, it is entirely proper for the proper officials of this Association to provide members with information and advice on such matters, leaving it to the


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ANNOUNCES CONTINUOUS COURSES

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GYNECOLOGY—Two Weeks Intensive Course June 18. One Week Personal Course Vaginal Approach to Pelvic Surgery July 9.

OBSTETRICS—Two Weeks Intensive Course June 4 and October 8.

ANESTHESIA—Two Weeks Course Regional, Intravenous and Caudal Anesthesia.

ROENTGENOLOGY—Courses in X-ray Interpretation, Fluoroscopy, Deep X-ray Therapy every week.

UROLOGY—Two Weeks Course and One Month Course every two weeks.

CYSTOSCOPY—Ten-Day Practical Course every two weeks.

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individual member to use his own judgment as to the soundness and validity of such advice.

"That, finally, members of the medical profession, by concentrating their efforts on improving and strengthening their own national, state and local medical societies are more likely to achieve the goals of unity of purpose and effective action than by scattering their interest and efforts among the several independent organizations now asking for their support, regardless of how worthy the purposes and motives of such organizations may be."

**Socialized Medicine**

The committee reviewed the thirteen bills from California which have to do with the creation of a health insurance plan, among them two major bills, one backed by the CIO and one by Governor Warren. The Public Health League, sponsored by the California Medical Association, also has a bill for the development of a voluntary system rather than a compulsory system of health insurance.

**The Journal**

*Report on advertising.* Total increase in advertising during January and February amounted to $996.60.

The committee was not in favor of increasing professional card rates for Indiana physicians.

*Cooperative Bureau advertising rates.* It was brought to the attention of the committee that the rates set by the Cooperative Advertising Bureau, which are the rates used for THE JOURNAL, are much lower than other advertising rates. It was reported that Mr. Roberts, local advertising agent, had recently received two contracts (from an agency from whom we also receive contracts) for a local society bulletin at forty dollars per page, as compared with the 1945 Journal rate of $36.00 per page for a twelve-time insertion, and which actually leaves only $29.88 per page after the agencies deduct their 15 per cent commission and 2 per cent discount.

Dr. Nafe was elected chairman of the Executive Committee for 1945.

There being no further business, the meeting was adjourned.

## LOCAL SOCIETY REPORTS

**CASS COUNTY MEDICAL SOCIETY** members held a meeting on April twentieth, at Logansport. The speaker was Dr. R. J. Masters, of Indianapolis, whose subject was "Ophthalmological Conditions in General Practice." Fifteen members were present.

**DELAWARE - BLACKFORD COUNTY MEDICAL SOCIETY** members met at Hotel Roberts, in Muncie, on April seventeenth. This was a routine business meeting. Twenty-four members were present.

The members held a business meeting at Hotel Roberts, in Muncie, on May fifteenth. Eighteen members attended this meeting.

**GRANT COUNTY MEDICAL SOCIETY** members met on April twelfth at Marion. Reverend Paul Weaver spoke about his work in Africa. A business meeting was also held.

**FLOYD COUNTY MEDICAL SOCIETY** members met at the Frances Cafeteria, in New Albany, on April thirteenth. Mrs. Irma Duer, of the New Albany Red Cross Chapter, discussed the veteran's pension and medical aid in relation to the private practitioner. Eleven members were in attendance.

At another meeting held on May eleventh the speaker was Dr. R. F. Bell, medical director of the Indiana Ordnance Works, at Charlestown. The title of his paper was "Industrial Medicine as Applied to the Indiana Ordnance Works." Thirteen members and guests were present.

**GREENE COUNTY MEDICAL SOCIETY** members held a dinner meeting at the Roosevelt Hotel, in Linton, on April twelfth. Eight members and guests were present, two dentists having been invited as guests.

**HOWARD COUNTY MEDICAL SOCIETY** members met at the St. Joseph Memorial Hospital, in Kokomo, on May fourth. The members had as their guests sixteen safety and personnel men from local factories. The speaker was Dr. Louis W. Spolyar, of Indianapolis, whose subject was "Industrial Dermatitis and other Industrial Hazards." Thirty-three members and guests were present.

**INDIANAPOLIS (MARION COUNTY) MEDICAL SOCIETY** members met on May first at the Indianapolis Athletic Club. Case reports were presented by Drs. Eugene F. Boggs, William V. Woods, J. H. Warvel, and Thomas Bauer, all of Indianapolis.

On May eighth Dr. Herman G. Morgan discussed "The Venereal Disease Control Program"; Dr. G. F. Kempf and Dr. A. M. Hetherington discussed "Public Health Problems," and Dr. Holland Thompson spoke on "Reporting of Tuberculosis."

The May fifteenth program was arranged by the staff of Billings General Hospital, under the direction of Lieutenant Colonel F. A. Rice. "Treatment of Osteomyelitis with Saucerization and Early Skin Graft" was the title of a paper read by Lieutenant Ernest M. Burgess, and "Nutritional Disturbances in Osteomyelitis" was discussed by Major Donald S. Thatcher.

At another meeting on May twenty-second Colonel Johnson McGuire, Medical Consultant for the Fifth Corps Area, spoke on "Cardiac Output with Reference to Congestive Heart Failure," and Colonel Beck, discussed the topic "How Far is Heart Survey going to Develop?"

**JAY COUNTY MEDICAL SOCIETY** members met on May fourth at the Country Club, at Portland. The speaker was Dr. J. D. Imhof, of Muncie, whose subject was "The Meanings of a Negative X-ray Report." Ten members were present.

**LAKE COUNTY MEDICAL SOCIETY** members met at the Mercy Hospital, in Gary, on April twelfth. Dr. Carl P. Huber, of Indianapolis, was the guest speaker, and his subject was "The Investigation and Treatment of Menstrual Irregularities." Sixty members attended the meeting.

**LAPORTE COUNTY MEDICAL SOCIETY** members met at the Wildwood Inn in LaPorte, on April fourteenth. The twenty-five members present heard Dr. Andrew J. Sullivan, of Washington, D. C., discuss "The Organization and Function of the Association of American Physicians and Surgeons."

**MADISON COUNTY MEDICAL SOCIETY** members met on April sixteenth, at the Mounds State Park. A motion picture was shown and the members had as their guest speaker Captain Theodore Peters, head of the Delco-Remy Division fire brigade.

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RESEARCH IN THE SERVICE OF MEDICINE

**MONTGOMERY COUNTY MEDICAL SOCIETY** members met on May Seventeenth at the Culver Hospital, in Crawfordsville. The guest speaker was Dr. Lester R. Dragstedt, of Chicago, who presented a paper on "Management of Peptic Ulcer." The meeting was attended by twenty members and guests.

**MORGAN COUNTY MEDICAL SOCIETY** members held a meeting at the Morgan County Memorial Hospital, in Martinsville, on April twenty-fifth. The seven members present were shown a motion picture.

**NOBLE COUNTY MEDICAL SOCIETY** members held a meeting at Kendallville on April twelfth. The seven members present reviewed past and present legislation affecting the practice of medicine.

**ST. JOSEPH COUNTY MEDICAL SOCIETY** members held a meeting on April twenty-fifth at Hotel LaSalle, in South Bend. The speakers at this meeting were all from the Gardiner General Hospital, in Chicago. Colonel John R. Hall spoke on "The Use of Penicillin in the Army," Major West discussed "The Use of Penicillin in Orthopedic Surgery," Major H. Dale Pyle presented "The Use of Penicillin in Internal Medicine," and Major Daniel D. Stiver spoke on "The Use of Penicillin from a Surgical Point of View." Attending the meeting were 135 members and guests.

The speaker at another meeting held on May eighth was Dr. E. W. Custer, of South Bend, whose subject was "Tuberculosis." Forty-four members and guests were present.

**TIPPECANOE COUNTY MEDICAL SOCIETY** members met at the Lincoln Lodge, in Lafayette, on May eighth. "Management of Skin Diseases," was the title of a paper read by Dr. John E. Dalton, of Indianapolis. Twenty-five members attended the meeting.

**VANDERBURGH COUNTY MEDICAL SOCIETY** members met at the Gold Room of Hotel McCurdy, in Evansville, on April tenth. The guest speaker was Dr. Jacob K. Berman, of Indianapolis, who spoke on "Head Injuries." Forty-seven members were present.

On May eighth, Dr. Charles B. Huggins, professor of Urology, University of Chicago, presented "Carcinoma of the Prostate," which was followed by a discussion. Thirty-eight members attended the meeting.

**WAYNE-UNION COUNTY MEDICAL SOCIETY** members held a meeting in conjunction with the Butler (Ohio) County Medical Society and the Union District Medical Society on April twenty-sixth, at Richmond, Indiana. Dr. William A. Davin, of Hamilton, Ohio, presented "The Diagnosis and Treatment of Cardiac Emergencies," and Dr. Gerald F. Kempf, of Indianapolis, spoke on "Chemotherapy," including a discussion of penicillin. The meeting was attended by fifty physicians.

## Councilor Meeting

### SIXTH COUNCILOR DISTRICT ASSOCIATION MEETING

The annual meeting of the Sixth Councilor District Association was held in Rushville at the Lollis Hotel on May tenth. Because of the volume of work being carried by the doctors of the district, no scientific program was prepared for this meeting. Dr. Jesse E. Ferrell, of Fortville, presented his resignation as secretary, and Dr. Perry Campbell, of Richmond, was elected to serve the unexpired term. Dr. W. U. Kennedy, the Councilor, made an excellent talk on state medicine. Fourteen physicians were present.

## *WOMAN'S AUXILIARY to the Indiana State Medical Association*

**President—Mrs. F. M. Gastineau, Indianapolis**
**President-elect—Mrs. S. J. Petronella, East Chicago**
**Corresponding Secretary—Mrs. C. L. Bock, Indianapolis**
**Treasurer—Mrs. A. W. Ratcliffe, Evansville**
**Press and Publicity—Mrs. A. B. Richter, Indianapolis**

### REPORT OF THE HOUSE OF DELEGATES MEETING — APRIL 25 AND 26, 1945

Mrs. F. M. Gastineau, of Indianapolis, president of the Woman's Auxiliary to the Indiana State Medical Association, entertained the twenty-seven members of the Board of Directors, chairmen of standing committees, and county presidents at dinner at the Indianapolis Athletic Club as the opening to the first annual meeting of the House of Delegates on Wednesday, April twenty-fifth. At this time the revisions to the constitution were discussed and tentative plans made for the fall meeting.

The following day the House of Delegates convened at the Columbia Club at 10:00 A.M. Mrs. F. M. Gastineau presided. During the day there were several inspirational speakers who discussed subjects of utmost importance to all auxiliary members. Dr. J. E. Ferrell, of Fortville, president-elect of the Indiana State Medical Association, extended greetings to the auxiliary, and in his discussion said, "The Physical Fitness Program is a highly important subject and deserves an enormous amount of thinking and action to bring it to its fullest bloom."

Dr. Norman Beatty, a member of the legislative committee of the Indiana State Medical Association, opened his remarks by congratulating the auxiliary upon the progress they have made by separating the House of Delegates meeting from the general medical convention in the fall. In addressing the group he stated that we now have the most progressive public health program in the history of the state. Bills passed in the recent legislature provide for (1) reorganization of the State Board of Health; (2) setting up a council on Mental Health; (3) organization of an Advisory Health Council of Indiana, which will insure public support; (4) provisions whereby local health departments may begin a program of construction of public health units; and (5) provision for a survey of hospital facilities in Indiana.

Mrs. A. H. Duemling, of Fort Wayne, third vice-president of the national organization, stated that in considering the Woman's Auxiliary to the American Medical Association one is impressed with the fact that the three qualities—intelligence, courage, and above all a sense of responsibility—have motivated the activities of our

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national organization during the twenty-two years of its existence. From a modest beginning of 440 members the auxiliary now has more than 25,000 members, threading forty-one states, and comprising 612 auxiliary units.

Mrs. Ronald M. Hazen, state director of the American Cancer Control Society, informed the delegates that in many counties over the state the cancer control committees were headed by doctors wives—some auxiliary members are on the speakers bureau, and some auxiliary groups are manning booths. She stated that with the money already collected they have furthered the educational program, have secured a medical secretary at the cancer clinic at the Indiana University Medical Center, have given a fellowship in pathology at the Medical Center, and have equipped a few clinics over the state at the request of doctors in those communities.

Mr. Thomas Hendricks, executive secretary of the Indiana State Medical Association, discussed various medical insurance plans currently used in some parts of the United States.

*Highlights of the Business Session*

1. The meeting was exceptionally well attended, showing active interest in the new plan of organization.

2. Treasurer's report, Mrs. A. W. Ratcliffe, treasurer: Balance on hand April 23, 1945—$976.13.

3. Membership, 945 members, showing an increase of 166 new members. Mrs. Gastineau diligently sent out letters to eligible persons who were not living in organized counties. Ninty-nine persons wished to become members at large and have sent in the one-dollar dues.

4. *Hygeia.* Mrs. O. H. Bakemeier illustrated her excellent report with a chart which brought the following facts to the attention of the meeting: (a) Cass, Sullivan, and Vigo counties exceeded their quotas; (b) Porter and Hancock reached their quotas; (c) Allan, Lake, and Marion received stars for tripling their number from the year before; and (d) St. Joseph County had no gain, but had a considerable number of subscriptions. It was voted that the state auxiliary enter the national *Hygeia* contest.

5. It was decided that the State Archive Chairman, Mrs. A. W. Morrison, keep clippings of activities to the state organization only. It was recommended that each county keep its own scrap book.

6. Mrs. Karl Koons, War Service Chairman, read a request from the W.A.C. Technician School at Camp Atterbury for issues of the following publications: *Hygeia, American Medical Journal of Technology, X-ray Technician, Radiography, American Journal of Nursing,* and *The Journal of the American Medical Association.* These issues are not to be more than a year old. It was recommended that each county contact its local war agency, asking them to help send the magazines. New subscriptions were discouraged because the school may be only temporary.

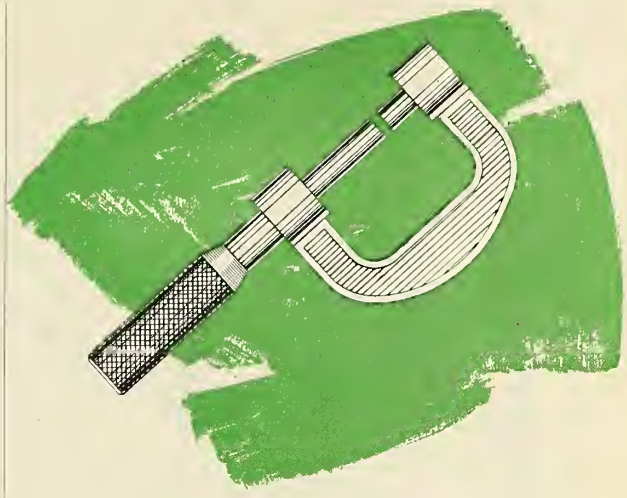
7. Physical Fitness. This is a new committee organized this year, and is headed by Mrs. N. H. Prentiss. She urged all counties to secure copies of the March, 1945, issue of THE JOURNAL of the Indiana State Medical Association and distribute them to athletic directors, principals, and physical education teachers in schools and colleges, also Y.M.C.A.'s and Y.W.C.A.'s.

Because of the radical change in the time of the meeting this year, there was no election of officers. The present group of officers will serve until April, 1946.

## Books

### BOOKS RECEIVED

**MY SECOND LIFE.** By Thomas Hall Shastid, M.D. 1174 pages with many illustrations. Cloth. Price $10.00. George Wahr, Ann Arbor, Michigan, 1944.

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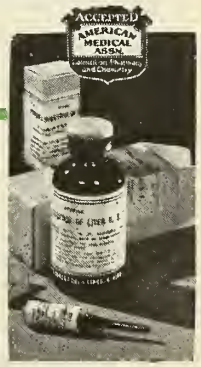


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*"Bactericidal Efficiency of Iodine Solutions and Organic Mercurial Antiseptics". Amer. Jour. Pharm., 117:5 (Jan.) 1945.

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★ ★

**DOCTORS AT WAR.** Edited by Morris Fishbein, M.D., editor of The Journal of American Medical Association. 418 pages with many illustrations. Cloth. Price $5.00. E. P. Dutton & Company, New York, 1945.

**THE EXAMINATION OF REFLEXES.** A Simplification. By Robert Wartenberg, M.D., 222 pages with 7 illustrations. Cloth. Price $2.50. The Year Book Publishers, Incorporated, Chicago, 1945.

**MASS RADIOGRAPHY OF THE CHEST.** By Herman E. Hilliboe, M.D., Medical Director, Chief, Tuberculosis Control Division, United States Public Health Service, Washington, D.C.; and Russell H. Morgan, M.D., Surgeon (R), Medical Officer-in-Charge, Radiology Section, Tuberculosis Control Division, United States Public Health Service. 288 pages with 93 illustrations. Cloth. Price $3.50. The Year Book Publishers, Incorporated, Chicago, 1945.

## REVIEWED

**A SYNOPSIS OF CLINICAL SYPHILIS.** By James Kirby Howles, M.D., Professor of Dermatology and Syphilology, and Director of the Department, Louisiana State University School of Medicine. 671 pages with 121 text illustrations and 2 color plates. Fabrikoid. Price $6.00. The C. V. Mosby Company, St. Louis, 1943.

*A Synopsis of Clinical Syphilis* is a compact work which gives very complete coverage of the various manifestations of this disease. It deals with the subject without superfluous verbiage, in condensed yet ample detail. It is compiled in such manner as to make it easy to refer to the different phases of the disease with a minimum of effort in locating the text or time spent in perusal.

MINOR MILLER.

**FUNDAMENTALS OF PSYCHIATRY.** By Edward A. Strecker, M.D., Professor of Psychiatry and Chairman of the Department, Undergraduate School of Medicine, University of Pennsylvania. 201 pages. Illustrated. Cloth. Price $3.00. J. B. Lippincott Company, Philadelphia, 1942.

*Fundamentals of Psychiatry* is a small book which gives the reader exactly what the title promises. It makes no pretense of being an exhaustive work on the subject. However, it does contain all that is necessary to give the student a working knowledge of neuropsychiatric practice. For the physician with limited knowledge on the subject, this book serves to acquaint the reader with the "know-how" in recognizing and dealing with the early diagnosis and management of this important branch of medical practice.

MINOR MILLER.

**THE MIDWEST PIONEER—HIS ILLS, CURES, AND DOCTORS.** By Madge E. Pickard and Dr. R. C. Buley, of the History Department of Indiana University, Bloomington, Indiana. Crown 8vo, 339 pages, illustrated. Bound in hand-blocked English paper covered boards. Price $5.00. R. E. Banta, Crawfordsville, Indiana, 1945.

Dr. Buley and Miss Pickard are the joint authors of "The Midwest Pioneer—His Ills, Cures, and Doctors," a scholarly and entertaining work on early medicine in the Middle West, which shows that in the first half of the nineteenth century there were evidenced some of the best, as well as some of the worst, features of medical education. This general history of pioneer medicine covers Indiana, Ohio, Illinois, Michigan, and Wisconsin, with some mention of Kentucky, Iowa, and Missouri. The crusading spirit of our own health officer, Dr. John N. Hurty, is also mentioned, which really brings the story close to us.

Rapid expansion of the country, the passion for business, and the high esteem placed upon practicality were not conducive to prolonged education for young men in any field of learning, according to the authors. Medicine, like the land, was even by those within the profession all too frequently exploited extensively rather than intensively.

"What the doctor lacked in training and knowledge he was supposed to compensate for with ingenuity and

the American's reputed ability to rise to any emergency, they say. This being the prevailing view, Dr. Daniel Drake, Dr. Benjamin W. Dudley, and Dr. Samuel Gross, men who devoted their lives to the serious study of medicine and the elevation of its standards and accomplishments, stand out in all the more distinct contrast."

The authors explain that in agriculture the American accepted improvements in machinery first, and easiest; these saved labor. Next came improvements in animals; they saved dollars. Last, and hardest to the farmer, came general science—soil chemistry, diets, plant pathology—the "book larnin" of the "printer farmers." So it was in medicine. The first to receive popular acceptance were the manual services of the profession, such as setting of broken bones, amputations, and the like, especially after the advent of anesthesia. Second came more general reliance upon the physician in cases of contagious diseases.

The story of pioneer medicine is told in a straightforward, non-technical manner; the book being divided into seven chapters: I, "He's Ailin'"; II, "Home Remedies and Domestic Medicine"; III, "Doctors: Bleed, Blister, and Purge"; IV, "The People's Doctors"; V, "Medical Odds: Anima to Zootes"; VI, "Who is a Doctor?"; VII, "Nirvana in Bottles—Drugs and Patents." The book is appropriately designed, beautifully printed on rag-content paper, and contains a complete bibliography, all of which augment the quality of the book.

We learn that the Midwest pioneers suffered from an almost incredible number of diseases, among them malaria, which menaced the population along the entire length of the Mississippi and the Ohio; smallpox, cholera, typhoid, milksickness, diphtheria, scarlet fever, measles, pneumonia, and tuberculosis. Under the circumstances all kinds of sectarians flourished, beginning with the Thomsonians, then the Botanico-Medicals, the Eclectics, the Homeopaths, and a great number and variety of unorthodox healers.

"Many persons who would not call a doctor for croup, dysentery, or rheumatism would do so for smallpox, diphtheria, or even measles," the authors say. "Last—and this after the pioneer period—came common acceptance of the germ theory, vaccines, hospitals, and preventive medicine.

"Medicine, as compared with applied science in mechanics was at a disadvantage. Advances in general education at times served but to make the people more critical of their doctors, who themselves were critical of each other. Though in retrospect this period of confusion in medicine proved to be salutary, it did not appear so at the time. If public confidence was not lost, it at least developed slowly and intermittently. At all times the pioneer reserved the sovereign right to try to make the science of medicine conform to his concept of democracy— to criticize, complain, refuse to regulate, do his own doctoring or none at all. Yet in spite of everything, folk cures, household remedies, 'hippos,' calomel, 'patent' pills and bottles, et cetera, some survived." But amid all this two Midwest physicians made a lasting contribution to the science of medicine: Dr. Ephraim McDowell, of Danville, Kentucky, performed the first operation for the removal of an ovarian tumor on a brave unanesthetized woman who lived thirty-one years after the operation; and Dr. William Beaumont, of Mackinac, Michigan, made his momentous discovery concerning the gastric juices while peering through a hole in the stomach wall of Alexis St. Martin, a half-breed Indian. Dr. John S. Bobbs, of Indianapolis, in 1867 performed the first gall bladder operation. Thus, the transition of American Medicine from the empiric period to the bona fide physician.

Indiana is particularly proud of this book which has been written by Hoosier authors, and which is not only a general history of the Midwest's medical pioneering, but a volume so charming and valuable to the history of medicine that a copy thereof should be added to the library of every book lover.


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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

*ISSUED MONTHLY under Direction of the Council*

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 38 JULY, 1945 Number 7


## ACUTE PEMPHIGUS

### REPORT OF A CASE WITH RECOVERY*


LIEUTENANT RICHARD H. GWARTNEY

MEDICAL CORPS, ARMY OF THE UNITED STATES


This case of acute pemphigus with recovery is presented for its clinical interest. While the literature is filled with reviews of pemphigus, reports of recovery from the acute form are rare. Some authors even go so far as to say that if the patient recovers the diagnosis of acute pemphigus is not valid.

A fifteen-year-old schoolboy entered the Ball Memorial Hospital on November 5, 1944, complaining of a generalized vesicular eruption.

The patient had been in good health until the last day of October, when he helped to unload a freight car of sacked potatoes at his place of employment. Following this he complained of being unusually tired. The next morning he worked from five until seven, but did not go to school because of a severe sore throat. He noted that there was a mucopurulent discharge from his nose, and that this discharge contained a large amount of dust. That afternoon he went to school, and then worked again in the evening. He did not eat his supper, and complained of burning in his throat and eyes. When the patient awoke the following morning his chest was covered by a rash which his mother thought was chickenpox. Although his throat was still painful and his conjunctival sacks were filled with purulent material, he did not feel ill. The next morning many vesicles had developed on his trunk. These were of various sizes, and the shapes varied due to coalescence of several lesions. His mother described his abdomen as being covered by a single "massive blister" which was partially filled with clear fluid, giving its contour a wrinkled appearance. His temperature was 104°, but he still did not feel ill. At this time he was seen by his family physician,** who gave him two grams of sulfadiazine followed by one gram every four hours. By November fourth, the fourth day of his illness, there were small vesicles and larger vesicles which might be described as bullae on his extremities. The large lesion on his abdomen had ruptured, and his temperature was now 100°.

The past history was essentially negative except for the following interesting features: at the age of seven and one-half years the patient suffered from a severe attack of scarlet fever. This was complicated by nephritis with anasarca, which lasted two weeks. There was no recurrence of urinary symptoms after recovery. During the summer months since 1937 he had experienced mild attacks of asthma, none of which necessitated medical attention. However, a paternal half-brother had suffered from rather severe bouts of asthma. The patient's father stated that as a boy he, too, developed a skin lesion on his arms which was diagnosed as shingles. However, on careful questioning it appeared that the vesicles were considerably larger than those which usually occur in herpes zoster. When this attack occurred his mother told him that his grandfather had once suffered from a similar rash.

Except for the striking skin lesions the patient's physical examination was negative. These lesions consisted of vesicles and bullae which were generalized in distribution but more discrete in form on the extremities. The individual lesions ranged from one to thirty centimeters in diameter, varied from round to oval in shape, and were located on an erythematous base (Figure I). Around the eyes and

* Written while a resident physician at the Ball Memorial Hospital, Muncie, Indiana.


** I wish to thank Dr. Clay Ball for permission to present this case.

FIGURE I

*This photograph was taken November 14, 1944, which was during the most critical period of the disease. Many small bullae are seen on the patient's knees. Note the massive lesion on the posterior surface of his right lower leg.*

mouth and on the trunk were large, oozing, raw, denuded areas where bullae had ruptured (Figure II). The mucous membrane of the mouth, throat, and nostrils was covered by a whitish-grey exudate, and there were ruptured and intact bullae present. The gums were spongy and bleeding. There were also lesions on the genitalia and around the anus. Nikolsky's sign† was present. The patient's alertness and his apparent lack of toxicity in the face of all of these lesions was a most remarkable feature.

At the time of admission the value for the hemoglobin was 16 grams per 100 cubic centimeters of blood. There were 5,210,000 erythrocytes and 8,300 leukocytes in each cubic millimeter of blood. A differential leukocyte count was normal in distribution, and there were no eosinophils present. The urine was found to contain a trace of albumin, several hyaline and granular casts, and numerous leukocytes. The Mazzini flocculation test for syphilis was negative. The blood plasma protein level and the albumin to globin ratio were normal, as was the hematocrit measurement carried out by the method of Wintrobe. The blood culture was negative. Numerous pus cells and moderate numbers of minute streptococci were found in the throat smear, and the same organism was grown on culture. There were occasional leukocytes in the smears of the material aspirated from the bullae, but no bacteria were found. However, a slight growth of nonhemolytic, anaerobic streptococci was obtained from this material when it was cultured.

FIGURE II

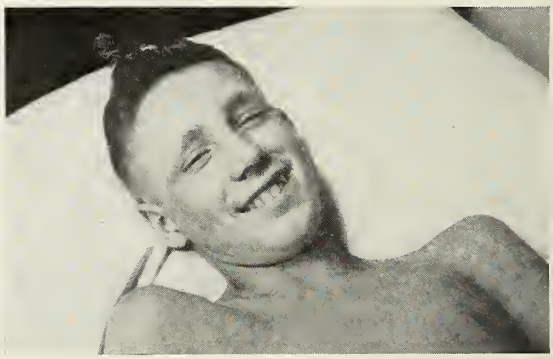
*Taken at same time as Figure I. Raw, oozing, denuded areas are seen around the eyes and on the lips, where bullae had ruptured. Note lack of cohesiveness between epidermis and dermis on neck and chest.*

† Nikolsky's sign is present when the bullae may be moved to adjacent areas without rupturing them. Also the epidermis where there are no bullae rubs off easily.

The patient was given a high caloric, high-vitamin, liquid diet and 300 milligrams of cevitamic acid intramuscularly, daily. He was placed on sterile sheets, and a cradle was used to hold the top sheets away from his body. At first powdered starch was applied to the lesions, and boric acid solution compresses to his eyes. Oral administration of one gram of sulfadiazine every four hours was continued.

By November tenth the denuded areas had become secondarily infected and sulfanilamide powder was substituted for the starch powder, and boric acid ointment was applied to the lesions around the eyes, lips, and in the nostrils. The following day he received 500 cubic centimeters of citrated whole blood.

FIGURE III

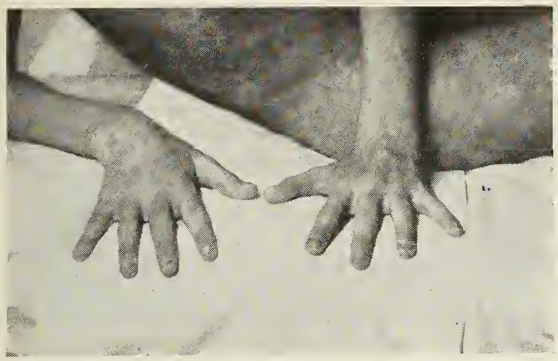


*Same patient, taken after recovery and approximately one month after Figures I and II were taken. Pigment absent from face as compared to chest.*

On November thirteenth there was a marked change in the patient's condition. Where he had formerly been alert, he now became apathetic, and there were periods when he was comatose. During this state he refused all nourishment. Most of the bullae had ruptured, the raw surfaces were infected, and the degenerating tissue had a most disagreeable odor. His temperature was 100.4°. For three days his prognosis was, indeed, considered fatal. On November seventeenth, the seventeenth day of his illness and the fifth day following his critical change, the lesions around his eyes and mouth were clearing, new skin was forming, and he was again quite responsive.

By November twentieth most of the lesions on his face were healed, and in their place was a mottled, reddish, dirty-brown pigmentation. The lesions on his extremities were also healing. At this time his erythrocyte count was only 3,100,000 cells in each cubic millimeter of blood with 10.5

FIGURE IV



*Taken at same time as Figure III. Loss of fingernails and pigmentation on trunk and extremities are shown.*

grams of hemoglobin per 100 cubic centimeters of blood, and he was given another blood transfusion. He was given plastules containing a daily total of 15 grains of ferrous sulfate, 7.86 grains of crude liver concentrate, and 2.25 grains of yeast. On this same date it is interesting to note that for the first time a good leukocyte response was manifest. There were 23,000 leukocytes in each cubic millimeter of blood, with the following differential distribution: lymphocytes 18 per cent; total neutrophils 82 per cent, with 40 band forms and 42 per cent polymorphonuclears. Other lymphocyte counts, on November fifth and November seventh, had contained, respectively, 8,350 and 8,200 leukocytes per cubic millimeter of blood, with a normal distribution of types.

On November twenty-first the temperature became normal and remained so. Previously it had ranged from 97.8° to between 100° and 101°, the high point usually being in the morning.

Three days later it was noted that his nails had become loose; he had lost all of the hair from his eyebrows, and was losing small amounts of hair from his head. The sulfadiazine was discontinued at this time, and the patient was permitted to be up in a chair. During the course of his illness he had lost twenty-five pounds in weight. When he was discharged from the hospital on December 1, 1944, all of the lesions were healed. However, there remained the reddish, dirty-brown pigmentation wherever the lesions had been located. By this time several of the loosened nails had fallen off, but he did not lose any more of his hair.

The patient was seen again on December fifteenth, at which time much of the pigmentation on his face had disappeared; however, that on his trunk and extremities was little changed (Figures III and IV). During the interval he had lost all of his finger- and toe-nails. He had regained about ten pounds of his lost weight, and felt perfectly well in every respect.

On January 4, 1945, the patient was given a series of scratch, skin tests for the determination of possible allergic reactions. This series included a large number of common foods, danders, pollens, house dust extracts, yeasts, fungi, and molds. The results were essentially negative. An attempt was made to obtain one of the potato sacks with which he had worked, for testing purposes, but unfortunately all of these had been destroyed or sold. In a nasal smear taken at this time there were 14 per cent polymorphonuclears, 86 per cent mononuclears, and no eosinophils. The pigmentation was still present on his body, but had lost its reddish hue, and it was almost completely cleared from his face.

When the patient was again seen on February tenth he had regained most of the lost weight, and had returned to school. The pigmentation on his trunk was somewhat lighter, and had disappeared completely from his face.

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## ABSTRACT

### ARMY DOCTORS REPORT "TRENCH MOUTH" TREATED WITH PENICILLIN

Two physicians in the United States Army Medical Corps, Lieutenant William F. Pearce and Captain John B. McDonald, report in the June 2 issue of *The Journal of the American Medical Association* that preliminary studies indicate that penicillin sodium was "distinctly superior" to all other forms of treatment for "trench mouth."

"From the point of view of the time required for cure," the two Army doctors said, "penicillin sodium was distinctly superior to all other forms of therapy. It has been our experience that older methods required daily care and observation for a minimum of ten days and usually much longer; with penicillin this was reduced to three days, the necessity of isolation was promptly eliminated, the relief of constitutional symptoms enabled the patient to resume his normal activities quickly, and further observation was required only once a week for two or three weeks. The reduction of treatment time and the diminishing cost of penicillin indicate that this method of therapy is both practical and economical for general office use."

"Trench mouth," known medically as Vincent's angina and Vincent's stomatitis, was first described in 1898 by a French physician named Vincent. It is an infection of the mouth and throat, due in part to a peculiar spiral organism. Symptoms include pain on swallowing, enlargement of the glands, and a yellowish gray membrane in the mouth and throat. During World War I the disease spread widely among the soldiers and was given the common name of trench mouth.

Lieutenant Pearce and Captain McDonald, who are stationed at Camp San Luis Obispo, California, conducted their studies on fifty men between the ages of eighteen and thirty-five. All patients were treated with muscular injections of penicillin sodium in doses of either 10,000 or 20,000 units every two or three hours night and day until a total of 100,000 to 200,000 units had been given. All of the patients were symptom free within twenty-four hours, and in most of them the gums and tonsils became clinically well in forty-eight to ninety-six hours.

"In the vast majority of the cases," the report in *The Journal* said, "the disease is not fatal or even serious, but the length of disability makes it an important factor in the health of an army or community and therefore its prompt eradication is highly desirous."

# GALLBLADDER, DUCT, AND BLOOD VESSEL ANOMALIES

HENRY S. LEONARD, M.D.

INDIANAPOLIS

The subject of anomalies of the gallbladder, extra hepatic ducts, and blood vessels supplying this field must of necessity be of interest to the surgeon. The fact that anomalies do exist is a constant challenge to the operator to be on guard at all times, lest he do irreparable damage during an operation.

It is estimated that variations from normal exist in 10 to 25 per cent of all cases. Regarding every case as a potential anomaly the surgeon must exercise every care by taking nothing for granted, and should carefully dissect out the cystic duct, common duct, and cystic artery before any clamp is applied or tissue cut.

From an embryological point of view we can find little to help explain the cause of anomalies. The liver appears in the embryo at about the third week. It is in the form of a bifid process and projects from the primitive foregut at a point which later forms the duodenum. This process has a rapid growth and gives off two solid buds of cells which represent the right and left lobes of the liver. The caudate portion of this process later forms the gallbladder and cystic duct, and the point of junction of these two parts will elongate to form the common bile duct. The opening of this common bile duct is originally on the ventral surface of the duodenum, but later rotates to the rear.

(1) Complete absence of the gallbladder is extremely rare, as is also a duplication, occurring once in three to four thousand cases, and is impossible to explain embryologically.

(2) Intrahepatic gallbladders have been seen and described by many authors.

(3) In many instances there have been persistent septa in gallbladders located either transversely or paralleling the long axis. In one of my own cases there was a persistent septum that divided the gallbladder into an upper and lower compartment. The upper contained pus and stones, and the lower stones and black bile.

(4) In two cases I have found gallbladders with long mesenteries, one having a torsion of the mesentery sufficient to produce a necrosis of the gallbladder. (See Figure I.)

(5) Hourglass gallbladders with stones in one or both cavities have been reported.

(6) Some cases are on record where the cystic duct has had a mesentery and the body and fundus of the gallbladder floated freely. (See Figure II.)

(7) Mention has been made of instances where the gallbladder was fixed to the left lobe of the liver.

Variations of ducts and blood vessels have been found so often that a special study of both was made by Eisendrath and Flint. The former gave special attention to the ducts, and the latter to the blood vessels.

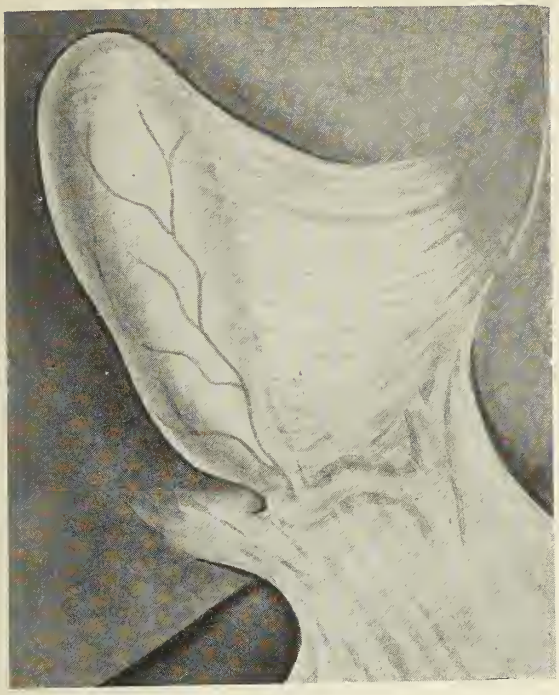
Normally, the hepatic duct is formed by the union of the right and left bile ducts descending from the liver. Usually the junction is at a point where they emerge from the liver. Often it happens lower down, and the hepatic duct is thereby shortened. The usual length is from one to two inches. It joins the cystic duct at an acute angle to form the common duct which descends along the right margin of the hepatoduodenal ligament.

In bile-duct anomalies and anatomic variations we have (1) an absence of the cystic duct and cystic artery with the gallbladder resembling a mucous cyst; (2) duplication of the cystic duct; (3) usual angular junction of cystic and hepatic duct is absent in 25 per cent of the cases; (4) in about one-third of the cases the cystic duct and hepatic duct lie in a parallel position for variable distances before forming the common duct; (5) in many instances (17 per cent) the cystic duct is recorded to have joined the hepatic duct either in front or behind it; (6) cystic duct has been known to have entered the duodenum as a separate channel; (7) accessory bile ducts exist in 15 per cent

FIGURE I

*A gallbladder floating free becoming twisted and gangrenous. A gangrenous appendix was found pointing upward at the junction of cystic and common duct. (The author's own case.)*

FIGURE II



*Another of the author's cases where the gallbladder had an extra long mesentery.*

of all cases; (8) instances of hepatocystic bile ducts have occurred where the right hepatic or a branch of it has opened directly into the gallbladder, and (9) extremely short cystic ducts.

Flint found accessory hepatic ducts in 15 per cent of his dissections. This would account for the excessive biliary drainage after the careful tying off of the cystic duct.

Injury to the bile ducts makes for biliary obstruction and thus increases damage to the liver.

### BLOOD VESSEL ANOMALIES

While anomalies are present in all regions of the body in respect to the vascular system, it is more common in the region of the liver.

Normally, according to all anatomists, the hepatica propria artery is a continuation of the hepatic after giving off the gastrica dextra and the gastroduodenalis at a level with the pylorus, and it ascends into the hepatoduodenale ligament to parallel the common bile duct. It divides into two branches near the porta hepatis, one a right and the other a left.

Ordinarily the right branch passes behind the hepatic duct, where it gives off a branch known as the cystic artery. In a normal case the bile duct would form the inner side of a triangle, the cystic duct the outer, and the cystic artery the northern boundary—this is known as "Calot's triangle."

If this situation always obtained it would simplify an operation, but according to studies by a number of anatomists 12 per cent of all individuals have two cystic arteries. Then, too, there are abnormal relationships of cystic duct and right hepatic arteries, according to Eisendrath. At times the two parallel each other closely.

This was demonstrated to a group of us by Sir James Walten, of London, England, during an operation for the removal of a gallbladder. He pointed out how easy it would be to ligate the right hepatic artery, when and if it lay directly alongside the cystic duct. In his judgment such a happening could account for many failures in cholecystectomies, and in all instances where this accident has occurred the patient was in a far worse condition than before operation, the result being a damage to the whole right lobe of the liver because of loss of blood supply, and in most instances death occurred. There may be anomalies in the course of the gastroduodenal artery and its branches, also the pancroduodenal in operations of the common duct.

Spalteholz's description of the cystic artery is very brief. He states that it is an artery given off to the gallbladder by the right hepatic. The fact is that it may come off the main hepatic artery. In some instances it may come as a branch of the left hepatic artery, and again it may be seen as a branch of the gastroduodenal.

In addition to the above-narrated anomalies there may be dense adhesions about the cystic duct and artery, obscuring the anatomy that lies at the bottom of the deepest and most inaccessible part of the operative field. Because of these anatomical and pathological changes it goes without saying that the operation of cholecystectomy is at times a hazardous one.

There is nothing so conducive to a good night's rest and to a feeling of well-being as to positively know that you have identified the cystic and common duct, and have securely ligated the cystic artery or arteries without damage to the extrahepatic ducts. Full surgical control should be sought and obtained in all instances.

The accidental tearing of the cystic artery or an anomalous vessel with the consequent obliteration of the field by a furious hemorrhage causes many an operator to become panic stricken and to resort to "grab-surgery." In an attempt to grasp the bleeding vessel which may have retracted the artery forceps are applied in a hit-and-miss manner and the extrahepatic duct or the right hepatic artery is caught and damaged.

Particular care should be exercised in cases where the tissues about the lower end of the cystic duct are indurated and friable. In this situation the artery clamp may cut through the artery, or the ligature that has been used to tie off the artery may not have been cut promptly, and the pull due to a retractor or the patient's straining may tear the ligature loose.

In conclusion, one is tempted to agree with Crile who said that a cholecystectomy can be one of the most difficult in all surgery.

# THE FIRST NITROUS-OXIDE ANESTHESIA ADMINISTERED BY DR. HORACE WELLS, DECEMBER 11, 1844—A MEMORIAL*

CHARLES N. COMBS, M.D.

TERRE HAUTE

In making an excursion into the subject of the History of Anesthesia we find ourselves in the field of polemics wherein gladiatorial contests are waged over priorities in discovery.

According to "The Transactions of the American Medical Association," published in 1870, a motion was passed by that body giving Horace Wells the official credit for the discovery of practical anesthesia. And now witness the unexpected eruption in the House of Delegates of The American Medical Association, in Chicago, as of last June. A seemingly innocent resolution was introduced by our Section on Anesthesia, as follows: "Whereas, 1944 marks the centenary of the discovery, by Horace Wells, of Hartford, Connecticut, of a practical method of anesthesia by nitrous-oxide, be it resolved that the House of Delegates of the American Medical Association commends and endorses the celebration during 1944 of the centenary of the discovery by Dr. Horace Wells, of Hartford, Connecticut, of a practical method for human anesthesia during surgical operations." Evidently the last few words suggested an undue pre-eminence. No sooner was that read than the loyal sons of Dixie leaped to their feet to defend the honor and memory of Crawford W. Long. The internecine feud between the North and the South was rekindled. The resolution was referred back again to the reference committee, and peace was secured by a more discriminatory phrasing of the resolution. The reference committee reported that they wished to give honor to whom honor is due, and to deny to no one seniority rights, and recommended the following substituted resolution: "Whereas, 1944 marks the centenary of the application of a practical method of anesthesia by nitrous-oxide, by H. G. Wells, of Hartford, Connecticut, therefore, be it resolved that the House of Delegates of the American Medical Association commends and endorses the celebration during 1944 of the centenary of the application of a practical method of anesthesia by nitrous-oxide, by Dr. Horace Wells, of Hartford, Connecticut." And so to this day does contention and disputatious rancor attend the name of Horace G. Wells.

It was on December 10, 1844, that a certain professor, G. Q. Colton, advertised in the Hartford, Connecticut, newspaper that he would demonstrate the exhilirating effects of laughing gas that evening at the Union Hall. In the audience were Dr. Horace Wells, well-known Hartford dentist, and his wife. One of the volunteers exhibited such excitement that he leaped from the stage and fell on one of the settees, producing a severe wound of his leg. As he subsided in the seat near Dr. Wells he expressed surprise that he had no consciousness of any pain, and it occurred to the good doctor that a tooth might be extracted under similar circumstances. Accordingly, the next morning he induced Professor Colton to administer the gas to himself, while Dr. Riggs, of pyorrhea fame, removed a molar with most successful results. During the succeeding few weeks Dr. Wells did fifteen extractions in the same manner, and was so thoroughly convinced of his discovery that he traveled to Boston to introduce it to the medical profession. He gave a lecture before the students of the Harvard Medical College, and finished by extracting a tooth from a young man. Unfortunately, his assistant removed the gas bag too soon, and the patient was only partially under. His outcries aroused jeers and hisses from the students who shouted "humbug." Now, if you, as I certainly do, remember early experiences with nitrous-oxide, you can readily sympathize with the situation. We have erratic performances even now with the most modern calibrated air-tight machines. We also can share in the humiliation suffered when the patient cried out as if in pain. We all have had such patients who volubly expressed their contempt for the anesthetic, but when it was over they had no recollection of any unpleasantness. Later, Dr. Wells went to Paris, where he received more recognition than was accorded him in America.

I would not overemphasize the role of Horace G. Wells. He was but one of a sudden flowering of genius in our specialty a century ago. True, he was a dentist, but that profession and ours have a common meeting ground in the realm of anesthesia. It is because of his contribution to our art and science that for the time being we disregard the claims of Snow, Hickman, Long, Morton, Jackson, *et alia*, and pause to memorialize the one hundred years since his original nitrous-oxide anesthesia. We do this not so much for what was then accomplished as for what he might have done had he not been so sensitive to early criticism.

Garrison's history of medicine, in giving the chronology of major medical events, mentions Long's operation under ether in 1842, and Morton's introduction of ether anesthetic in 1846, but does not list the name of Wells under the year 1844. Thus, during the past century in the history of anesthesiology the furor about the discovery of

* Presented before the Section on Anesthesia of the Indiana State Medical Association, at Indianapolis, October 4, 1944.

anesthesia has raged. The followers of Wells have been as intransigent and irreconcilable as those of the others, and have kept alive his achievements by succeeding resolutions in the Connecticut and the National Legislative halls and by erecting stained glass windows, pew ends, busts, and monuments, not only in Hartford but in Washington, Boston, and even in France. Dr. Charles Wells, of Syracuse, New York, a few years ago published a comprehensive biography defending the claims of his namesake and listing the posthumous awards, memorial plaques, statues, et cetera, attesting the later recognition of his fame. Indeed, his invincible surmise might have languished as such, had not later scientists corrected the defects of nitrous-oxide and augmented its advantages. Of these, we could mention E. Willys Andrews, who prolonged its action by the addition of oxygen, McKesson who perfected an apparatus for the exact percentage method of administration, and Ralph Waters who developed an exactitude of measurement, extracting the diluent carbon-dioxide by means of soda lime filter.

Monuments, graved in stone or molded in bronze, are subject to the relentless corrosion of time, or suddenly disappear from fire, earthquake, or spiteful demolition by invading armies, but the memories of great men and great events will never perish as long as the human spirit retains its faculties of memory and gratitude. By word of mouth, from generation to generation, remembrance will serve to perpetuate notable advances.

In 1848, depressed by ill health and chagrined by the controversy over the discovery of anesthesia, he died by his own hand at the early age of thirty-three. Such was the end of a pioneer who dared to suggest a new idea to the smug and satisfied physicians of his time.

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## ABSTRACTS

### ONE INJECTION OF PENICILLIN IS USED TO TREAT GONORRHEA

A single injection of calcium penicillin in beeswax-peanut oil may now be used successfully in the treatment of gonorrhea, according to the study reported in the June 9 issue of *The Journal of the American Medical Association.* The report, based on 175 cases, was made by Captain Monroe J. Romansky and Captain Robert J. Murphy, Medical Corps, Army of the United States, and Technician (3rd Grade) George E. Rittman, Medical Department, Army of the United States.

The preparation is made with calcium penicillin—which is a combination of penicillin not so easily dissolved as the more commonly used sodium penicillin—highly refined peanut oil and chemically pure beeswax, all blended together. The purpose of this mixture is to prolong the action of the penicillin, thus increasing the effectiveness of a single injection. After a single injection of 100,000 units of this preparation, penicillin remains in the blood for seven and one-half to ten hours. By contrast, a single injection of 100,000 units of penicillin in a salt solution will produce a high blood level of penicillin in the first hour, but the penicillin entirely disappears from the blood in about four hours and is therefore active for only a short time.

The authors found that 150,000 units in a single dose was most satisfactory. Among seventy-five patients treated with this dosage there were no failures.

The rapid disappearance of the clinical symptoms of the disease was striking. Eighty-three per cent showed improvement in twelve hours and 95 per cent by the end of twenty-four hours. The rest improved by the end of three days.

"The injection of the penicillin in beeswax-peanut oil produced no immediate discomfort," the doctors said. "Twenty-four hours following the injection slight soreness was present to pressure, but this was gone within forty-eight hours." None of the patients showed any reaction to the mixture.

The authors noted that "in view of studies which are now being conducted, single daily injections of penicillin in beeswax-peanut oil have also proved effective in pneumonia, impetigo, staphylococcic infections and other conditions which respond to penicillin in saline solution.

### PENICILLIN IS EFFECTIVE FOR SYPHILIS OF NERVOUS SYSTEM

A serious type of syphilitic disease—syphilis of the nervous system—has been effectively treated with penicillin, as demonstrated in the preliminary report of cases by Douglas Goldman, M.D., of Cincinnati, in *The Journal of the American Medical Association* for May 26. Dr. Goldman reports that only two out of eighteen cases treated with penicillin did not show definite improvement.

"Some degree of clinical improvement is manifested in practically every one of the remaining patients," he states. "Eight cases show evidence of rapid remission which can be expected to lead to complete recovery within a short time. Nine others have shown within the period of observation improvement of varying degree which is sufficiently definite to justify an optimistic outlook for eventual recovery."

Since no definite technic for the use of penicillin in syphilis has as yet been established, Dr. Goldman initiated this study with the purpose of trying different technics. Two methods of management were followed.

In the first group the patients received penicillin by spinal and muscular injection. No local manifestations from the treatment were observed in spite of the large doses of penicillin administered. Eight of ten patients had fever on one or more days following the injections. In every instance the temperature returned to normal before the treatment was completed and apparently remained normal despite continued injections of large doses of penicillin. Dr. Goldman believes that the proper interpretation of these changes is to consider them a manifestation of so-called "treatment shock" rather than an effect of the penicillin itself.

The second group of patients was treated with a combination of artificial fever and muscular injections of penicillin. These patients showed no toxic effects whatever from the penicillin. No fever reaction was observed and the management of the fever was in no way affected by the use of the penicillin. Dr. Goldman observed that "it seems that the administration of three or four fever treatments before injection of penicillin is an effective means of avoiding therapeutic shock."

In an assay of the two methods, the doctor stated that the results in the patients treated with fever and penicillin are practically similar to those in patients treated with the combinations of muscular and spinal injections of penicillin.

# INTRATHECAL PENICILLIN IN CEREBRAL SPINAL SYPHILIS

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This is a preliminary report on the results obtained with the intrathecal injection of penicillin in the treatment of central nervous system lues. This work was begun in August, 1944. A wide variety of central nervous system cases were selected, and no other treatment was given at the same time. Some seventy cases have been treated to date. Twenty-five were treated at the Indiana University Hospital and Medical Center, and forty-five at the Indianapolis City Hospital. This work was undertaken to find out what could be accomplished by this one method of treatment.

Dr. Edith Haynes, of the Pathological Laboratory of Indiana University, found that penicillin introduced intrathecally remains in the spinal fluid somewhat over twenty-four hours. This confirms the work of others along this same line. Dr. Haynes also found that after 3,500,000 units of penicillin had been given intramuscularly (40,000 units every three hours) no penicillin could be demonstrated in the spinal fluid. This fact, of course, has been reported by many other workers. In view of these facts, it seemed reasonable to assume that perhaps additional clinical results might be obtained by the intrathecal method.

We started with 10,000 and 20,000 units, but found the 20,000 units well tolerated, so quickly changed to this as standard. We tried cases on daily, weekly, fortnightly, and monthly injections, and found that the weekly injections seemed the most practical. The injections were given by the Swift-Ellis technique. The bloods and spinal fluids were checked by Dr. L. Y. Mazzini, and I hereby express my sincere thanks for his whole-hearted cooperation and assistance in this work. I also acknowledge the valuable assistance of Dr. Paul E. Humphreys, the resident in Dermatology and Syphilology at the Indianapolis City Hospital, in the giving of intrathecal treatments. I also wish to thank the resident staff and nurses at the Indiana University Hospital for their splendid cooperation in this work, and, last but not least, my gratitude to Miss Margaret McCauley, the head nurse at the Dermatology and Syphilology Clinic at the Indianapolis City Hospital, for her untiring work and assistance in following up these cases.

*Case No. 1*

L. H., aged seventy-two, male, white.

Diagnosis: Tabes dorsalis.

Previous treatment: Treated by a private physician for one and one-half years.

Clinical findings before treatment: Before beginning treatment patient required a cane and assistance in walking. He was confused mentally, and had retention of urine.

Treatment started October 10, 1944—240,000 units of penicillin.

| *First Spinal Wassermann* | *Tenth Spinal Wassermann* | *Twelfth Spinal Wassermann* |
|---|---|---|
| .1 cc. 1+ | .1 cc. 3+ | .1 cc. negative |
| .2 cc. 4+ | .2 cc. 4+ | .2 cc. 4+ |
| .3 cc. 4+ | .3 cc. 4+ | .2 cc. 4+ |
| .4 cc. 4+ | .4 cc. 4+ | .4 cc. 4+ |
| .5 cc. 4+ | .5 cc. 4+ | .5 cc. 4+ |
| G. 0000000000 | G. 0000000000 | G. 0000000000 |
| | | Cell count: 0 |
| | | Total protein: 92 mg. |
| | | Pandy: faint trace |

Blood reports: Wassermann, Kahn, Kline, and Kahn quantitative, negative.

Clinical findings after treatment: Walks without assistance; has gained three pounds in weight; no longer incontinent; and residual urine is greatly reduced.

Spinal fluid serology: Unimproved.

*Case No. 2*

O. L., aged thirty-three, female, white.

Diagnosis: General paresis.

Previous treatment: 7 bismuth.

Clinical findings before treatment: Mentally confused. Loss of weight.

Treatment started October 11, 1944—260,000 units of penicillin.

| *First Spinal Wassermann* | *Tenth Spinal Wassermann* | *Thirteenth Spinal Wassermann* |
|---|---|---|
| .1 cc. 4+ | .1 cc. 4+ | .1 cc. negative |
| .2 cc. 4+ | .2 cc. 4+ | .2 cc. negative |
| .3 cc. 4+ | .3 cc. 4+ | .3 cc. 2+ |
| .4 cc. 4+ | .4 cc. 4+ | .4 cc. 4+ |
| .5 cc. 4+ | .5 cc. 4+ | .5 cc. 4+ |
| G. 5555420000 | G. 4333322000 | G. 1111110000 |
| | | Cell count: 0 |
| | | Pandy: faint trace |
| | | Total protein: 92 mg. |

Clinical findings after treatment: Mentally and physically improved; seventeen-pound gain in weight.

Spinal fluid serology: Improved.

*Case No. 3*

I. C., aged fifty-nine, female, white.

Diagnosis: Paresis with psychosis.

Previous treatment: Malariotherapy in 1939 at the Central State Hospital; 53 bismuth; and 33 tryparsamide.

Clinical findings before treatment: Loss of memory, incoherent, and undernourished.

Treatment started October 11, 1944—280,000 units of penicillin.

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| *First Spinal Wassermann* | *Tenth Spinal Wassermann* | *Fourteenth Spinal Wassermann* |
|---|---|---|
| .1 cc. negative | .1 cc. 1+ | .1 cc. negative |
| .2 cc. 2+ | .2 cc. 4+ | .2 cc. 2+ |
| .3 cc. 4+ | .3 cc. 4+ | .3 cc. 4+ |
| .4 cc. 4+ | .4 cc. 4+ | .4 cc. 4+ |
| .5 cc. 4+ | .5 cc. 4+ | .5 cc. 4+ |
| G. 0000000000 | G. 5223310000 | G. 4333331000 |
| | | Cell count: 0 |
| | | Pandy: negative |
| | | Total protein: 64 mg. |

Blood reports: Wassermann, 1 plus; Kahn quantitative, negative.

Clinical findings after treatment: Six-pound gain in weight, mentally alert, and physically improved; in fact, he was the most improved mental patient under treatment.

Spinal fluid serology: Unimproved.

*Case No. 4*

M. B., aged fifty-eight, female, colored.

Diagnosis: Central nervous system syphilis.

Previous treatment: 106 bismuth; 50 tryparsamide; 6 neosalvarsan, and 1 silver salvarsan.

Clinical findings before treatment: Mentally and physically weak.

Treatment started October 18, 1944—260,000 units of penicillin.

| *First Spinal Wassermann* | *Tenth Spinal Wassermann* | *Thirteenth Spinal Wassermann* |
|---|---|---|
| .1 cc. 4+ | .1 cc. 4+ | .1 cc. negative |
| .2 cc. 4+ | .2 cc. 4+ | .2 cc. 4+ |
| .3 cc. 4+ | .3 cc. 4+ | .3 cc. 4+ |
| .4 cc. 4+ | .4 cc. 4+ | .4 cc. 4+ |
| .5 cc. 4+ | .5 cc. 4+ | .5 cc. 4+ |

Blood reports: Wassermann, 4 plus; and Kahn quantitative, 20 units.

Clinical findings after treatment: Some improvement mentally and physically, and a four-pound gain in weight.

Spinal fluid serology: Improved.

*Case No. 5*

M. B., aged fifty-four, male, white.

Diagnosis: General paresis and aortic aneurysm. Complicating factor: Exfoliative dermatitis following tryparsamide therapy in 1940.

Previous treatment: 58 bismuth; 3 tryparsamide.

Clinical findings before treatment: Loss of weight. Mentally confused.

Treatment started October 13, 1944—260,000 units of penicillin.

| *First Spinal Wassermann* | *Tenth Spinal Wassermann* | *Thirteenth Spinal Wassermann* |
|---|---|---|
| .1 cc. 4+ | .1 cc. 2+ | .1 cc. negative |
| .2 cc. 4+ | .2 cc. 4+ | .2 cc. 1+ |
| .3 cc. 4+ | .3 cc. 4+ | .3 cc. 1+ |
| .4 cc. 4+ | .4 cc. 4+ | .4 cc. 3+ |
| .5 cc. 4+ | .5 cc. 4+ | .5 cc. 4+ |
| G. 5554411000 | G. 5554331000 | G. 5555544322 |
| | | Cell count: 2 |
| | | Pandy: trace |
| | | Total protein: 55 mg. |

Blood reports: Wassermann, 4 plus; Kahn quantitative, 40 units.

Clinical findings after treatment: Weight gain, five pounds; clinically much improved.

Spinal fluid serology: Improved.

*Case No. 6*

B. M., aged forty-two, female, colored.

Diagnosis: General paresis without psychosis.

Previous treatment: 90 bismuth; 50 tryparsamide. Inoculated with malaria in 1941—unsatisfactory results.

Clinical findings before treatment: Incoherent.

Treatment started October 25, 1944—280,000 units of penicillin.

| *First Spinal Wassermann* | *Tenth Spinal Wassermann* | *Fourteenth Spinal Wassermann* |
|---|---|---|
| .1 cc. 3+ | .1 cc. 4+ | .1 cc. negative |
| .2 cc. 4+ | .2 cc. 4+ | .2 cc. 4+ |
| .3 cc. 4+ | .3 cc. 4+ | .3 cc. 4+ |
| .4 cc. 4+ | .4 cc. 4+ | .4 cc. 4+ |
| .5 cc. 4+ | .5 cc. 4+ | .5 cc. 4+ |
| G. 5554210000 | G. 5555431000 | G. 5554411000 |
| | | Cell count: 0 |
| | | Pandy: negative |
| | | Total protein: 29 mg. |

Clinical findings after treatment: Mentally and physically improved.

Spinal fluid serology: Improved.

*Case No. 7*

J. W., aged forty-five, male, colored.

Diagnosis: Meningovascular central nervous system syphilis. Hemoplegia of right leg and arm. Aortic insufficiency.

Previous treatment: Treatment begun in 1941 included 51 bismuth, 23 mapharsen, 3 phenarsine, 11 tryparsamide, and iodides.

Clinical findings before treatment: Aphasia and right hemiplegia.

Treatment started October 27, 1944—220,000 units of penicillin.

| *First Spinal Wassermann* | *Tenth Spinal Wassermann* | *Eleventh Spinal Wassermann* |
|---|---|---|
| .1 cc. negative | .1 cc. 1+ | .1 cc. negative |
| .2 cc. 1+ | .2 cc. 4+ | .2 cc. 4+ |
| .3 cc. 4+ | .3 cc. 4+ | .3 cc. 4+ |
| .4 cc. 4+ | .4 cc. 4+ | .4 cc. 4+ |
| .5 cc. 4+ | .5 cc. 4+ | .5 cc. 4+ |
| G. 1121100000 | G. 0000000000 | G. 0000000000 |
| | | Cell count: negative |
| | | Pandy: negative |

Blood reports: Wassermann, 4 plus; Kahn quantitative, 20 units.

Clinical findings after treatment: Return of function of right leg and arm. Speech improved. Weight unchanged. Physically improved.

Spinal fluid serology: Unimproved.

*Case No. 8*

B. D., aged fifty-eight, female, colored.

Diagnosis: General paresis.

Previous treatment: 12 bismuth; 9 tryparsamide.

Clinical findings before treatment: Charcot's joint of left knee. Mentally confused.

Treatment started November 11, 1944—260,000 units of penicillin.

| *First Spinal Wassermann* | *Tenth Spinal Wassermann* | *Thirteenth Spinal Wassermann* |
|---|---|---|
| .1 cc. 4+ | .1 cc. 2+ | .1 cc. negative |
| .2 cc. 4+ | .2 cc. 4+ | .2 cc. 2+ |
| .3 cc. 4+ | .3 cc. 4+ | .3 cc. 4+ |
| .4 cc. 4+ | .4 cc. 4+ | .4 cc. 4+ |
| .5 cc. 4+ | .5 cc. 4+ | .5 cc. 4+ |
| G. 3333222000 | G. 1112331000 | G. 3334455544 |
| Cell count: 1 | | Cell count: 0 |
| Pandy: negative | | Pandy: negative |
| Total protein: 97 mg. | | Total protein: 49 mg. |

Clinical findings after treatment: Physically and mentally improved; gained three pounds in weight.

Spinal fluid serology: Improved.

*Case No. 9*

W. B., aged sixty, male, white.

Diagnosis: General paresis.

Previous treatment: 21 bismuth; 24 tryparsamide. Malaria contraindicated.

Clinical findings before treatment: Walking difficult; patient undernourished.

Treatment started November 11, 1944—260,000 units of penicillin.

| *First Spinal Wassermann* | *Tenth Spinal Wassermann* | *Thirteenth Spinal Wassermann* |
|---|---|---|
| .1 cc. 4+ | .1 cc. negative | .1 cc. negative |
| .2 cc. 4+ | .2 cc. 3+ | .2 cc. 1+ |
| .3 cc. 4+ | .3 cc. 4+ | .3 cc. 2+ |
| .4 cc. 4+ | .4 cc. 4+ | .4 cc. 3+ |
| .5 cc. 4+ | .5 cc. 4+ | .5 cc. 4+ |
| G. 1111000000 | G. 4433210000 | G. 0112211000 |
| Cell count: 0 | Cell count: 0 | Cell count: 2 |
| Pandy: faint trace | Pandy: negative | Pandy: negative |
| Total protein: 48 mg. | Total protein: 49 mg. | Total protein: 59 mg. |

Blood reports: Wassermann, 4 plus; Kahn quantitative, 20 units.

Clinical findings after treatment: Physically improved; walks more steadily; and has gained three pounds in weight.

Spinal fluid serology: Improved.

*Case No. 10*

G. M., aged fifty-six, male, colored.

Diagnosis: Asymptomatic central nervous system syphilis.

Previous treatment: None. Referred from Veterans Hospital with positive blood and spinal fluid Wassermann.

Clinical findings before treatment: Nervous, with some mental confusion and inability to work.

Treatment started November 24, 1944—260,000 units of penicillin.

| *First Spinal Wassermann* | *Tenth Spinal Wassermann* | *Thirteenth Spinal Wassermann* |
|---|---|---|
| .1 cc. 3+ | .1 cc. 2+ | .1 cc. negative |
| .2 cc. 4+ | .2 cc. 4+ | .2 cc. 1+ |
| .3 cc. 4+ | .3 cc. 4+ | .3 cc. 3+ |
| .4 cc. 4+ | .4 cc. 4+ | .4 cc. 4+ |
| .5 cc. 4+ | .5 cc. 4+ | .5 cc. 4+ |
| G. 5555321000 | G. 5555321000 | G. 5554311000 |
| Cell count: 1 | Cell count: 20 | |
| Pandy: faint trace | Pandy: negative | |
| Total protein: 47 mg. | Total protein: 32 mg. | |
| Wassermann: 4+ | Wassermann: 4+ | Wassermann: 4+ |
| Kahn: 20 units | Kahn: 20 units | Kahn: 40 units |

Clinical findings after treatment: Weight unchanged; sleeps better, and nervousness improved. Mentally more alert, and is able to work.

Spinal fluid serology: Improved.

*Case No. 11*

A. W., aged twenty-seven, female, colored.

Diagnosis: Latent syphilis.

Previous treatment: Started treatments in 1940, including 27 neoarsphenamine, 2 phenarsine, 21 tryparsamide, and 18 bismuth.

Clinical findings before treatment: Severe headaches; some mental confusion; and lack of memory. Chronically tired.

Treatment started November 8, 1944—280,000 units of penicillin.

| *First Spinal Wassermann* | *Tenth Spinal Wassermann* | *Fourteenth Spinal Wassermann* |
|---|---|---|
| .1 cc. negative | .1 cc. negative | .1 cc. negative |
| .2 cc. 1+ | .2 cc. 4+ | .2 cc. negative |
| .3 cc. 4+ | .3 cc. 4+ | .3 cc. negative |
| .4 cc. 4+ | .4 cc. 4+ | .4 cc. 1+ |
| .5 cc. 4+ | .5 cc. 4+ | .5 cc. 1+ |
| G. 3333311000 | G. 1112231000 | G. 0000000000 |
| Cell count: 4 | Cell count: 28 | Cell count: 0 |
| Pandy: negative | Pandy: faint trace | Pandy: negative |
| Total protein: 105 mg. | Total protein: 51 mg. | Total protein: 32 mg. |
| Wassermann: 3+ | | Wassermann: 1+ |
| Kahn: 3+ | | Kahn: negative |
| Kline: 4+ | | Kline: negative |
| Mazzini: 4+ | | Mazzini: 1+ |
| Kahn quantitative: negative | | Kahn quantitative: negative |

Clinical findings after treatment: Mentally alert; physically improved; no headaches; and a six-pound gain in weight.

Spinal fluid serology: Improved.

*Case No. 12*

M. S., aged forty-five, female, white.

Diagnosis: Central nervous system syphilis.

Previous treatment: 4 bismuth.

Clinical findings before treatment: Routine blood and spinal check both positive. Severe headaches.

Treatment started November 20, 1944—260,000 units of penicillin.

| *First Spinal Wassermann* | *Tenth Spinal Wassermann* | *Thirteenth Spinal Wassermann* |
|---|---|---|
| .1 cc. 1+ | .1 cc. negative | .1 cc. negative |
| .2 cc. 4+ | .2 cc. 1+ | .2 cc. negative |
| .3 cc. 4+ | .3 cc. 3+ | .3 cc. negative |

| | | |
|---|---|---|
| .4 cc. 4+ | .4 cc. 4+ | .4 cc. negative |
| .5 cc. 4+ | .5 cc. 4+ | .5 cc. negative |
| G. 0000000000 | G. 0000000000 | G. 0000000000 |
| Cell count: 1 | Cell count: 0 | |
| Pandy: negative | Pandy: negative | |
| Total protein: 45 mg. | Total protein: 62 mg. | |

Blood reports: Wassermann, 4 plus; Kahn quantitative, 40 units.

Clinical findings after treatment: Physically improved; no headaches; and a ten-pound gain in weight.

Spinal fluid serology: negative.

*Case No. 13*

C. H., aged seventy-two, male, colored.

Diagnosis: Central nervous system syphilis. Bilaterial primary optic atrophy.

Previous treatment: none.

Clinical findings before treatment: Mentally confused; nearly blind, and assistance needed in walking.

Treatment started December 4, 1944—260,000 units of penicillin.

| *First Spinal Wassermann* | *Tenth Spinal Wassermann* | *Thirteenth Spinal Wassermann* |
|---|---|---|
| .1 cc. 4+ | .1 cc. negative | .1 cc. negative |
| .2 cc. 4+ | .2 cc. 3+ | .2 cc. 1+ |
| .3 cc. 4+ | .3 cc. 4+ | .3 cc. 4+ |
| .4 cc. 4+ | .4 cc. 4+ | .4 cc. 4+ |
| .5 cc. 4+ | .5 cc. 4+ | .5 cc. 4+ |
| G. 1233300000 | G. 113210000 | G. 0011100000 |
| Cell count: 1 | Cell count: 8 | Cell count: 0 |
| Pandy: faint trace | Pandy: negative | Pandy: negative |
| Total protein: 39 mg. | Total protein: 48 mg. | Total protein: 47 mg. |

Blood reports: Wassermann, 4 plus; Kahn quantitative, 20 units.

Clinical findings after treatment: Completely blind; eighteen-pound gain in weight; improved physically.

Spinal fluid serology: Improved.

*Case No. 14*

J. S., aged thirty-five, male, colored.

Diagnosis: Asymptomatic syphilis with left retrobulbar neuritis.

Previous treatment: 10 bismuth; 15 neoarsphenamine; and malariotherapy in 1941.

Clinical findings before treatment: Mentally confused; underweight; and eye weakness.

Treatment started December 4, 1944—260,000 units of penicillin.

| *First Spinal Wassermann* | *Tenth Spinal Wassermann* | *Thirteenth Spinal Wassermann* |
|---|---|---|
| .1 cc. 4+ | .1 cc. 4+ | .1 cc. negative |
| .2 cc. 4+ | .2 cc. 4+ | .2 cc. 2+ |
| .3 cc. 4+ | .3 cc. 4+ | .3 cc. 4+ |
| .4 cc. 4+ | .4 cc. 4+ | .4 cc. 4+ |
| .5 cc. 4+ | .5 cc. 4+ | .5 cc. 4+ |
| G. 1111131000 | G. 1112110000 | G. 0003210000 |
| Cell count: 4 | Cell count: 0 | Cell count: 15 |
| Pandy: negative | Pandy: negative | Pandy: negative |
| Total protein: 42 mg. | Total protein: 42 mg. | Total protein: 43 mg. |

Blood reports: Wassermann, 4 plus; Kahn quantitative, 10 units.

Clinical findings after treatment: Five-pound gain in weight; physically improved; and mentally improved.

Spinal fluid serology: Improved.

*Case No. 15*

E. P., aged forty-four, male, white.

Diagnosis: Asymptomatic central nervous system syphilis.

Previous treatment: 13 bismuth.

Clinical findings before treatment: Mentally confused; loss of weight.

Treatment started January 1, 1945—200,000 units of penicillin.

| *First Spinal Wassermann* | *Tenth Spinal Wassermann* |
|---|---|
| .1 cc. negative | .1 cc. negative |
| .2 cc. negative | .2 cc. negative |
| .3 cc. negative | .3 cc. 1+ |
| .4 cc. 2+ | .4 cc. 3+ |
| .5 cc. 4+ | .5 cc. 4+ |
| G. 1111000000 | G. 0000000000 |
| Cell count: 0 | Cell count: 0 |
| Pandy: faint trace | Pandy: negative |
| Total protein: 101 mg. | Total protein: 33 mg. |

Blood reports: Wassermann, 3 plus; Kahn quantitative, 40 units.

Clinical findings after treatment: Improved mentally and physically.

Spinal fluid serology: Unimproved.

*Case No. 16*

M. R. P., aged thirty-three, female, colored.

Diagnosis: Central nervous system syphilis and syphilitic iritis.

Previous treatment: 9 neoarsphenamine.

Clinical findings before treatment: Iritis. Spinal report partially positive.

Treatment started January 15, 1945—120,000 units of penicillin.

| *First Spinal Wassermann* | *Fifth Spinal Wassermann* |
|---|---|
| .1 cc. negative | .1 cc. negative |
| .2 cc. negative | .2 cc. negative |
| .3 cc. negative | .3 cc. negative |
| .4 cc. negative | .4 cc. negative |
| .5 cc. 4+ | .5 cc. negative |
| G. 1112210000 | G. 1121100000 |
| Cell count: 2 | Cell count: 11 |
| Pandy: faint trace | Pandy: negative |
| Total protein: 51 mg. | Total protein: 43 mg. |

Blood reports: Wassermann, 4 plus; Kahn quantitative, 10 units.

Clinical findings after treatment: Iritis better. Improved physically.

Spinal fluid serology: negative.

Clinical improvement begins first, and this is followed much later by serological improvement in the spinal fluid. A few cases show no clinical or serological improvement. It is too early to tell how many treatments can or should be given. Meningeal

and meningovascular treatments seem to respond best. Paretics respond much better than expected. The Swift-Ellis technique, it is to be remembered, is not satisfactory in paretics. Locomotor ataxia responds well. Syphilitic spinal myelitis reacts well to this treatment, but no better than to the Swift-Ellis. Optic atrophy does not seem to be checked by intrathecal penicillin, but the number of cases are too few at present for conclusive evaluation. Intrathecal penicillin can be used in cases where malaria is contraindicated because of physical condition or age.

Conclusion: Many cases respond favorably to intrathecal penicillin, but much work must be done to establish its exact place with the many other kinds of treatment used for central nervous system lues. Best results are obtained by a judicious and careful selection of several methods for any particular case of central nervous system lues.

# RELATION OF WHOOPING COUGH TO TUBERCULOSIS

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During the past three years I have been employed by the Goodyear Engineering Corporation, in the hospital at the Hoosier Ordnance Plant. During this time I have read many x-ray plates of applicants applying for work. The x-ray plates have disclosed that many of this number have arrested pulmonary tuberculosis. They were ignorant of the fact that they at one time had active pulmonary tuberculosis, yet without medical advice, hospital, sanitarium, or other treatment they made a spontaneous recovery. Why did they recover and become arrested cases? If we knew the answer to this question, then we would know the treatment to administer to an active case of tuberculosis.

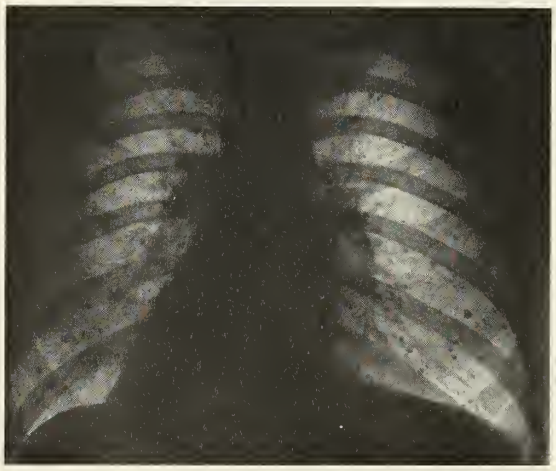
In interviewing these applicants and getting a history of past illness which they had suffered a surprising large number gave this history:

At the age of twelve, thirteen, fourteen, or fifteen they had an attack of whooping cough. Upon recovery of the whooping cough they have enjoyed good health continuously since that time. Accordingly, pulmonary tuberculosis existed prior to the attack of whooping cough—not since.

For example, the following pictures made from x-ray plates illustrate:

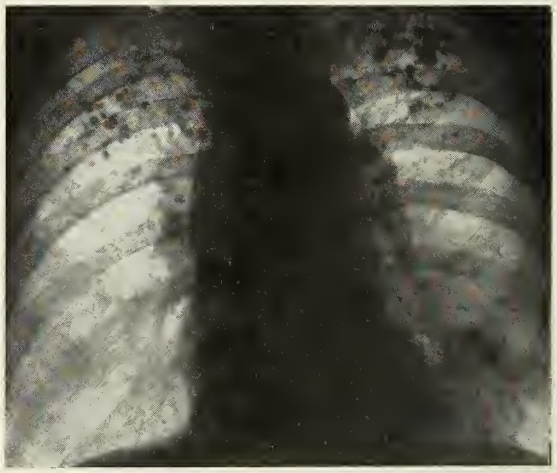
*Case No. 1.* This applicant, thirty-six years of age, weighs 180 pounds, has a ruddy complexion, is well-muscled, and gives the following history: At the age of fourteen he suffered an attack of whooping cough. He has enjoyed good health since recovery.

CASE NO. 1



*Case No. 2.* This applicant, seventy years of age, is now an employee at the Hoosier Ordnance Plant. At the age of fourteen he suffered a severe attack of whooping cough. As he put it, "I coughed, whooped, and puked." There was no other history of illness. He has worked at manual labor all his life.

CASE NO. 2



Conclusion: The toxin produced by the pertussin bacilli either inhibits the growth or destroys the tubercle bacilli.

This being true, then the logical treatment to administer to an active case of tuberculosis is pertussin vaccine or pertussin antigen, dosage and frequency of dosage to be determined clinically. This treatment would do the patient no harm, and to prove whether the theory advanced is true or false patients must be treated and results noted.

Any physician or sanitarium treating an active case or cases, if they will give this treatment a trial, may obtain the vaccine or antigen gratis if they write to me for information as to where it may be secured, with the understanding that the results are to be reported.

*THE JOURNAL*
OF THE
INDIANA STATE MEDICAL ASSOCIATION
DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA
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JULY, 1945

# Editorials

## RELEASE OF SERVICE PHYSICIANS

Elsewhere in this number appears a formal statement from our Executive Committee anent a very important matter—the release of medical men now in service who are no longer absolutely needed there. With the close of the European phase of the present World War there comes the discharge of several hundred thousand enlisted men. Right now, shipload after shipload of these men dock at various points along the Atlantic coast.

Many of these returning soldiers are, of course, but on their way to the Pacific, yet a host of them are to be discharged. Thus, the need for men for medical services is greatly lessened in Europe, and it is to this point that the plea of our committee is directed.

In an editorial note in this issue is a brief comment concerning the change in plans in regard to having returning medical personnel man our Veterans Administration hospitals; this plan has been relegated to the background, and we hear little more about it. Manifestly, this was a very unfair, ill-conceived notion in the first place.

While Indiana Medicine wants to continue its all-out policy in any matter that will expedite the end of the war in the Pacific, yet we feel that the time has arrived when a large group of doctors can be released without lowering in any degree the efficiency of the medical department of the Army and the Navy.

We need a lot of doctors here in Indiana. Many of the old guard who have been working overtime for several years past now find themselves at about the end of the string; they want a little respite from their long, arduous task, and this can be accomplished only by the return of some of the thousand or more medical officers now in service from Indiana.

We are proud of the record of our Hoosier servicemen; every last one of them has done a good job, some of them laboring under conditions impossible to describe. And, *if* it is at all possible for some of these men to be released, we trust that this may be done soon.

## IRA E. PERRY

Dr. Ira E. Perry, of North Manchester, died recently at his summer home at Lake Webster, at the age of seventy-two. In his passing, Indiana Medicine lost another "landmark," one who spent a lot of time in the furtherance of his profession, to which he was most devoted.

For some thirteen years Ira Perry served as Councilor of the Eleventh Councilor District, and his present term would have expired on December thirty-first. Only recently during a conversation with Doctor Perry, he remarked, "I think it about time I retire from this job and let some younger man take over." We do not know what his final decision may have been in that regard. We do, however, know of the work the man did for his profession—how faithful he was to his duties as district councilor. We know that he spent considerable time on medical matters as a result of holding that office, and that he had much to do in making the Eleventh District an outstanding medical society.

We recall the one session of the Council he missed; it was held at Indianapolis during the winter season, when a blizzard was raging. Train service was out of the question, so he started to drive to the capital city. He phoned from someplace near Logansport, stating, "I just can't make it; my car refuses to buck the drifts, so I am heading back home. I'm sorry." He was just like that. He wanted to do his part, and it irked him no end when he was unable to do the things he thought needed to be done. We have known Doctor Perry a long time, and on many occasions have gone to him for counsel, always getting the best of advice.

Thus, do we mourn the passing of another great and good man—a true physician, and we sorrowfully dedicate a page in our annals to his memory.

## CHARLES EUGENE FERGUSON

In the passing of "Charlie" Ferguson, Hoosier Medicine loses another "pillar," a man who had long endeared himself to the many hundreds of students who had attended his classes, over a long period of years. He was in many ways a most unusual man; he knew everyone of his students and took time to pass many a quip with them. He had held the title of professor emeritus longer than any other man in the history of the medical school. His death occurred shortly before he would have attained his eighty-ninth birthday, on May twenty-ninth.

In a newspaper story anent his passing, it was remarked, "The noted professor and physician attributed his long life to his refusal to permit anything to worry him, and to his keen interest in literature, medicine, and his fellow man." It is the latter that chiefly interests those of us who knew this man over a long span of years. He thoroughly believed in his "fellow man," thus accounting for the thousands of intimate friends that were his.

Almost a quarter century ago his vision began to fail, and in a few years he was totally and incurably blind. However, this did not deter the man from carrying on much as he had done in former years. He, of course, had to give up his beloved teaching post, but kept abreast of current literature, and managed to keep up with the post-graduate courses offered by mail by the medical department of a neighboring state university.

Naturally, he was a radio fan; current news always interested him, and he managed to find time to listen in on the better musical programs. The Indiana State Library supplied him with current literature, in the form of phonograph records, and through these various agencies he kept abreast of current times.

We like to think of Charlie Ferguson as we best knew him when we sat in his classes, and later when we would meet him in the "smoker" session of our annual association meetings. We know of no Indiana physician who enjoyed these get-to-gethers more than he did. As we have heard him say, "I just mill about the room, trying to see everybody there." Even with the coming of blindness he did not forego these gatherings for a long period of time. Invariably, he was among those present, and his table was the center of the most animated group in the hall. One had but to approach his table and say "Hello, Charlie," and his face would immediately light up. He would then call the greeter by name, and at once ask some intimate questions.

To most of his students in his later teaching years he was affectionately known as "Daddy Ferguson," and in the more than thirty years he taught he acquired a host of friends, most of whom he never forgot.

His was a busy life, and years ago we often wondered how the man managed to do all the things he did and still have time for a brief chat with his friends. His office was where the Federal Building now stands, in what was known as "Doctor's Row." There he was flanked by such eminent men of the time as The Jamesons, P. H. and Henry; Allison Maxwell; Robert Todd; Evan Hadley; and a host of others whose names are prominent in the annals of Hoosier Medicine.

He served for a year as the head of the Indianapolis City Hospital, leaving that post to take over the secretaryship of the Indianapolis City Board of Health.

He generally is credited with having much to do with the installation of the first city water filtering plant in Indianapolis. He was somewhat of a traveler at times, having visited the clinics of several European medical centers, and also managed to be in Japan during the Russo-Japanese War, some forty years ago. He also spent some time in China.

So we record the passing of a true "Hoosier Great," a man universally loved, and one who never lost his interest, nor his faith in his fellow man. His passing gives an added value to the medical diploma we acquired more than four decades ago. In those days these instruments were of huge size and bore the signature of not only the officers of the medical school, but those of every department head. So it is that this added value comes from the signature of "Charles E. Ferguson, M.D."

Peace to his memory!

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## MALARIA

With the coming of the summer season, which among other things brings to most sections of Indiana an influx of mosquitoes, medical circles are concerned about malaria, a disease that for many years seemed to have lost its foothold in most parts of the Hoosier state. However, with the unusual rainy season that has prevailed in most sections of Indiana for the past several weeks, these pesky "critters" already are all too common hereabouts. We walk out into our yard either early in the morning or late evening and hear the hum and feel the sting of these little fellows. Only this morning, about sunrise, we went out to refill the bird bath, an operation requiring but a few moments, and killed no less than three mosquitoes which had decided to find a meal at our expense. No, we did not take time to check on the variety, hence do not know whether or not they were of the Anopheles genus; we just slew 'em.

And, speaking of the Anopheles, they are commonly found right here in Indiana; so we are told by those who know their mosquitoes—they even reach up into neighboring Canada.

The malaria hazard is markedly increased by the fact that we will have thousands of returning soldiers, men who for many months have been living in the heart of the malaria country, which will materially add to the number of potential cases. It is

estimated that in this country there are at least two million cases each year, with something like five thousand deaths.

Only a short time ago we had veritable epidemics in certain sections right here in Indiana—so many cases, in fact, that health authorities were aroused, no end. Drainage of swampy areas will materially aid in the control of these pests, as will the elimination of pools of stagnant water. The greatest breeding spots in cities and towns are in old tin cans allowed to stand about the alleys, partly filled with water. Other breeding spots, we have personally observed, are in dense plots of shrubbery, especially those in which long grass is permitted to grow.

A few years ago one side of our yard was allowed to just grow. We called it "the jungle," which it was, on a small scale. While this was permitted to remain we had a horde of mosquitoes about the place, but after it had been cut out and grass allowed to grow. we noted an immediate diminution in the mosquito supply.

Naturally, the first thing to do in combating the danger that appears in the offing is a well-planned and well-executed mosquito control program. Standing, stagnant water must be eliminated; weeds must not be permitted to grow at random; homes must be universally screened, and, not the least important, care must be exercised while vacationing.

The old stand-by remedy, quinine, continues to be scarce, and while atabrine is doing the good job that is being done, it is, after all, only a substitute. We of the medical profession must be on the alert, that we may recognize the condition at once and institute the proper treatment. By due care in exercising all possible preventive measures, plus an early recognition of the disease, we can do much to help a situation that now appears somewhat ominous.

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## "COUNTRY PRACTICE"

Much speculation is being engaged in as to the future of country practice, much of this being brought about by the fact that thousands of medical men now in the armed services have before them the problem of what to do after the war has ended and they have been discharged. To the great majority the problem is whether to return to their old field or to open an office elsewhere. Also, the problem of specialization is being gravely considered by many of these men.

There is another group of servicemen with whom these problems are not so acute; they never had been in private practice, having entered the service immediately following the conclusion of their internship. However, this group, too, is doing a bit of thinking about the future.

Some anxiety exists in certain circles concerning the future of the so-called "country practice," a type of practice that has changed to a very great extent over the past few years. Back in the old days this type of practice meant many hardships, what with limited means of transportation and very poor roads in most sections of Indiana. Today this picture has changed; country practice does not necessarily mean settling down at some crossroads corner, such as was the case several decades ago. Back in those days the medical office commonly was found right there — at the crossroads. Perhaps it was a postoffice town, with a country store and a village blacksmith. Occasionally some physician living right out in the country built himself a two-room office down in the corner of the front yard. No matter where he was located, it seems that the countryside lost little time in locating him when the need came for his services.

But as we have said, country practice no longer means that here in Indiana. Our roads are not surpassed in any other state; telephone service is available everywhere, and with the modern automobile the doctor can answer a call at any point in his territory within a few minutes. In addition to this, hospital facilities are not too far distant in most sections.

Country practice now usually means that one locates in a sizeable city or town in the community, commonly the county seat. With electricity now available all over the state, with "bottled gas" delivered at one's front door, and with private water systems so practically made and easily installed, the country doctor now has every advantage enjoyed by his city brethren, and even many additional ones.

In many of our county-seat towns the medical care problem is approaching the acute stage. Several former practitioners have enlisted; a few have died; and those that remain find their increasing years a real burden when it comes to the daily calls for medical care. We have in mind one prosperous town of that sort, where but a few years ago some half dozen or more physicians had plenty to do — they were busy most of the time. Now the story is different, only about two of the original group remains, and replacements must be had.

We would urge young men now in service to seriously consider taking up a location in some such city or town, and there are many such spots in Indiana. The building up of a practice will be greatly expedited since there is plenty of work for well-trained men. Do not be in a hurry about "moving to the city and becoming a big-shot specialist"; there is plenty of time to think about that. And be it remembered that while you are carrying on in the country you are building up a store of medical knowledge that you probably would not get in city practice, for country doctors have to be on their toes every minute. They cannot call for consultation so frequently; they have to act on their own. Think it over!

# Editorial Notes

Many doctors in service have been more than commonly disturbed by an announcement made some time ago by the Veterans Administration, that service physicians might be called upon to man the veterans hospitals in this country. It now can be stated that these difficulties are being ironed out, and that service physicians, at the conclusion of their present tasks, will be permitted to return to private practice.

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Michigan Medical Service announces an increase of benefits to subscribers, with no increase in rates. Some 800,000 subscribers will be entitled to these additional benefits, the Service announces. Among the liberalizations are the removal of the previous limit of one hundred and fifty dollars for surgical service provided under the Schedule of Benefits and performed at the same time or for the same purpose; and shortening of the waiting period for maternity care from ten months to nine months. These are the chief changes made by the Service. Michigan Medical Service announces a continued rapid expansion, stating that only recently some four hundred groups sent a request to be enrolled therein.

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Mrs. Robert W. Long, widow of the late Dr. Robert W. Long, died recently at the hospital bearing her late husband's name. The hospital was a gift to Indiana University by Dr. and Mrs. Long several years ago. Of late years she had made her home at the Marott Hotel, in Indianapolis. Her father was said to have been the first physician to locate in Montgomery County. She had reached the ripe age of ninety-one at the time of her death.

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It is reported that one of the first things Dr. Thurman B. Rice plans to do after he is relieved of his post as acting secretary of the Indiana State Board of Health will be the writing of a series of articles on the divorce problem—and what a problem that is! Doctor Rice long has been interested in "The American Home"; his writings for some years past have reflected that, and now he plans to attack the most vulnerable spot in the entire problem. There can be no question but that divorces are all too common. They are too easy to obtain. On occasion we have been in court when divorce proceedings were being heard, and it seemed that it was but a matter of moments to get a decree. We do not know what Dr. Rice's plan of attack will be, nor what solution he has to offer, but we feel that here is the man most eminently qualified to attempt such a solution, and we shall be very much interested in following his articles.

This year the Woman's Auxiliary to the Indiana State Medical Association tried a new experiment, that of having its House of Delegates meeting in April instead of in connection with its fall meeting. Accordingly, the annual reports are published in this issue, which will give the members ample time to study them before their fall meeting. We are sorry that it has become necessary for all society reports to be set in smaller type, but with our present paper limitation we think it better to conserve space in this manner than to omit some of the contents. THE JOURNAL appreciates the cooperation and support given us by the Auxiliary, and are especially grateful to Mrs. Arthur B. Richter, the press and publicity chairman, for her consideration and assistance in working out the necessary details.

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Cancer, one of the most dreaded diseases incident to mankind, took an enormous toll in Indiana this past year; in fact, it claimed the largest number of victims in the history of the state. A large insurance company states that while this is true, it also is a fact that there was a decrease of about eleven per cent in the number of deaths among its women policyholders. This would seem to bear out the contention we long have made, that women are, by far, more cancer-conscious than men. In our personal experience the very great majority of inquiries concerning cancer come from our women patients. It is hoped that the new State Board of Health setup will be able to do something about the cancer situation in Indiana—not that the previous health officials have been lax in any degree, but that at long last "Official Indiana" has become vitally interested in this and many other health problems.

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At this writing, June sixth, the prospect of holding our annual session appears to be very poor, and at the same time it appears that we will not be able to have a meeting of our House of Delegates, at least not for many months. The American Medical Association has been officially advised that a permit for a meeting of its House of Delegates will not be issued, and several state organizations have had similar advice. As suggested in THE JOURNAL some months ago, it would be well for our Council and our Executive Committee to see just what plan might be adopted to have some sort of a meeting, in order that constitutional provisions may be carried out. With a limit of fifty set for any such meeting, this will, of course, be quite some task. However, if some substitute plan is adopted, then in the event that the no-convention order is later rescinded we will have protected ourselves. District meetings could be held, each district appointing a committee to attend a state meeting later on in the year. In this way we could handle the necessary business of the association, and at the same time be within the constitution.

A one-room school for crippled children recently was opened in Muncie. This room was most appropriately named the Dr. Harry E. Mock Room, Dr. Mock having lived and practiced in Muncie in his early medical career—now an orthopedist, in Chicago. Pupils for this school are transported to and from their homes via school buses. Desks in the room were adjusted according to the need of the occupants, and the lighting was arranged according to requirements in each case. This is a most forward movement, one which might well be emulated in many of our cities.

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According to the local press, a Muncie physician who was busy at his office, received a hurry-up call from an anxious mother, who suddenly became quite concerned about a young son. Declaring the lad to be critically ill, she persuaded the physician to leave his office at once and go to the home. However, the mother could not find the patient, once the physician had arrived; "Jimmy was around here a while ago, I'll see if I can find him," she said. The lad finally was located in the neighborhood, *playing ball.* Meantime, a score of patients were sitting in the office of the physician awaiting his ministrations.

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Psychiatry, a most important phase of medical practice—and it is becoming more and more so each day—seems to be "on the up." Recognizing its importance and the limited number of medical men trained in that branch, steps are being taken to correct that shortage. Here in Indiana we soon will have a psychiatric school for post-graduate work. We have the physical equipment, which soon will be augmented by new buildings, and we have the teaching staff necessary for the success of such a school. Then, too, it has been officially recognized that Indiana must have an additional state hospital for mental cases, and that need will be met in due time.

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"Vox Pop" letters, as found in various Indiana newspapers, sometimes give a lot of information We recently came across such a letter in the *Evansville Courier,* written by a woman subscriber living in Cannelton. She was speaking of medical progress. As a young girl, living in the upper peninsula of Michigan, she was for some days confined to her home by an illness. During that period diphtheria broke out in the town, in epidemic form. Doors of her home were locked and the windows plugged up, lest the infection get into the house. Fourteen children died of diphtheria within three blocks of her home, and she saw the little white caskets being borne away to the cemetery. She then goes on to tell of the present-day medicine and what it has done to relieve such intolerable situations, concluding that in the last thirty-five years medicine has really gone places—and it is still going places.

The *New York Times* announces that a sum of one-half million dollars is being raised for the expansion of the library of the New York Academy of Medicine. Carleton H. Palmer heads the committee in charge of the project. Among other changes, a nine-story addition to the stack room is to be added, thus giving capacity for the storage of 374,000 additional volumes. This library is at present the most-used library in the Western Hemisphere.

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The Indiana lay press continues to side in with Hoosier Medicine in the plea that everything possible should be done to ease the war burden now placed upon the shoulders of the medical profession. From our clipping service we get two or three such articles every few weeks, all of which ask the public to make house call requests early in the morning. Another suggestion found in a story in the *Franklin Star* calls attention to another time-taking habit of a lot of people, that of calling the office and insisting on talking with the doctor rather than this secretary. Too often such calls are of a nature that can easily and properly be handled by the secretary, thus saving time for the busy physician.

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Complaint is general regarding a shortage of photographic film, roentgenologists in particular finding this material hard to get. The war, of course, is responsible for much of this, since huge quantities of film are used by the armed services. With an imminent slowing down of industry we find that many employers of large groups of workmen are having x-ray examinations made of all these ere they leave the employment, which materially adds to the problem of getting enough film. One of the Indianapolis hospitals recently announced that they had found it necessary to "farm out" many patients, sending them to local doctors who were fortunate enough to have some film on hand.

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The Union Hospital, at Terre Haute, has announced plans for an addition to that institution, the estimated cost of which will be $350,000. This announcement was made at a recent dinner meeting, attended by the hospital staff, its board of managers, and sundry city and civic officials. An outstanding feature of the program of the evening was the presentation of a scroll to Dr. Charles N. Combs, for many years connected with the hospital, and for the last several years serving as its superintendent. Mayor McMillan, in making the presentation, thus addressed Doctor Combs: "For the valuable services you have rendered to this community and for the large part you have played in making this institution what it is today, I salute you, on behalf of the citizens of Terre Haute."

One of the immediate effects of the ending of the European phase of the war, and one that affects our profession, is the large amount of medical and dental supplies that will no longer be needed there. For example, complete x-ray equipment, as well as complete laboratory layouts, will be available in large numbers. It is stated that it is the policy of the government to sell such equipment at a low price to hospitals in this country that normally could not afford to purchase such material. It is planned to make this distribution under the direction of the Public Health Service and the State Boards of Health. There can be no question but that such a plan will meet with general approval. Too often such supplies are "jobbed" to the highest bidder, who puts them on sale at high prices.

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We would like to make our usual talk about vacations for members of our profession, but are stymied. There are a lot of things we could recommend for such an outing, many places where we could advise you to go, pointing out certain fishing grounds that are of the never-fail variety, but how can we get there? In the main, train travel is out. One might find a seat on a train, bound for the North Woods, but we would not advise that unless one has a real Simon Pure reservation, going and coming. "Resort Specials," "The Fisherman's Specials" and all that sort of thing still are out and definitely will not be put into service for the duration. About the only ray of hope is that with the end of the war in Europe there *might* be a little letup in gasoline restrictions, which would be of some help; at least we could get up into northern Indiana for a bit of fishing. But we do not mean that one should get the vacation notion entirely out of one's head. If it is nothing more than a week at old Aunt Mary's, better take it.

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*Coronet Magazine*, for April, carries a most readable article by Morris Fishbein, "The Last Great Quack," referring to the late John R. Brinkley, he of "goat gland" fame. Brinkley, it will be remembered, used the radio for his advertising and, as advertising goes, did a swell job of it. After his local station had been closed by government officials he opened a huge station below the Mexican border and carried on from there. Occasionally we tuned in, just to hear his latest bluster, most of which was royally entertaining. Fishbein, who had a most intimate acquaintance with the doings of Brinkley, much of which was incident to a suit by Brinkley against the American Medical Association, in which he was the loser, and during which trial—occupying the time of a court for many weeks—much information was revealed as to just how he operated. There is no doubt but that John Brinkley was the arch quack of all time, but we doubt that he is "the last great quack," as Fishbein has dubbed him. Quackery pays good dividends, and until such a time as federal and state laws are radically changed, we will have plenty of quackery to contend with.

The Metropolitan Life Insurance Company announces that on September first it will close the tuberculosis sanatorium it has maintained for treatment of its employes affected with that disease. The institution is located near Saratoga, New York, in the foothills of the Adirondacks. Since it was opened, in 1913, it has treated some 3,500 employes. However, in recent years the number of cases has been so small that it was determined best to close the sanatorium and treat such cases as might need hospitalization in other institutions, the company paying the costs thereof. This is but another indication that tuberculosis, long one of our most dread diseases, is slowly being conquered.

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We had thought the craze for "freak shape" lenses had passed, now that the "Harlequin" plastics no longer are the choice of certain folk, but evidently we were wrong. In the rimless variety some "genius" has concocted the most outlandish shapes yet to come to our notice. These can serve but one purpose, that of appealing to the wearer; certainly few others will agree that they materially add to the appearance. But the latest comes in a young woman who wants a certain freak style, all because the artist who does her hair says that this lens shape is just what she will have to have "to match her hair style!" What will the poor girl do a few months hence, when she adopts a new hair-do?

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In an editorial entitled "Degrading Medical Education," which appeared in *The New York Times* of April 10, 1945, we are reminded of the hazards that can befall the medical profession unless constant vigilance is kept around the legislative hopper. *The New York Times* stated it so well that we take the liberty of quoting it herewith:

"At its recent session the State Legislature passed the Milmoe Bill, which would make it possible for anyone who has received the degree of Bachelor or Doctor of Medicine from some medical school in this country, and who has served nine months as an intern in an approved hospital, to take the state examination in medicine, and, if he passes, to receive a license to practice. At one stroke the work of the late Dr. William Welch, Dr. Abraham Flexner, and the American Medical Association is to be undone. Thanks to their efforts, our best medical schools have few equals anywhere in the world. If the Governor should sign the Milmoe Bill, the diploma mills that withered and died would revive and physicians would have to fight again a battle which they thought they had won.

"The supposed justification for the Milmoe Bill is an undeniable shortage of physicians. But this should not be made an excuse for lowering standards of medical education. Under the pressure of war our medical schools have already curtailed courses and done away with long vacations. We ought not go beyond this and open the doors wide to the practice of medicine by men who would be weeded out in a year by any of the first-class schools. Whatever our medical situation may be, it is not so low that we must accept an incompetent who has managed to obtain a degree from a second, or third-rate medical school. Bad medicine can be worse than no medicine. There is still time to scotch this menace to medical education. The Governor has only to veto the bill, and we trust that he will."

# President's Page

## THE OASIS BECOMES A MIRAGE

Men have long dreamed of Utopias where the economic problems of production and distribution are solved; where men learn to live together as brothers, and the less favored groups are the care of all the favored; where there are new and far reaching standards of values, and all are perfectly happy.

These lovely vistas arise in the hearts of men burdened with distress, and in nations sick with war and depression. In themselves they may be harmless, wishful thinking—a fantasy world created of hopes and desires, but when seized upon by those who seek to mold them into a dream-world of power, political prestige, and domination they become the carnal desires of cupidity and leave a mess of ashes in the mouth.

Such is the recently-proposed expansion of the Social Security Act, presented to the Senate by Senators Wagner and Murray, and to the House of Representatives by Representative Dingell. It seeks to provide for national security, health, and public welfare. Such an idealistic proposal sounds very grand, and no one can quarrel about the aims it sets forth. However, when we begin to examine the bill and inquire into the ways and means it seeks to employ in order to accomplish these aims, we begin to learn that this Utopian realm is to be realized only through a complete and thorough disruption of our entire social, economic, and political life. It proposes to promote the individual, and at the same time to shackle and depress the system that sustains and prospers him.

The definition of purposes in the bill is couched in the language of the true humanitarian. The principles enunciated as a guide to administration are sound and ethical, but the philosophy and the mechanics of administration are wholly totalitarian in concept and operation. There is no essential difference between this and previous bills submitted by Wagner, Murray, and Dingell, except that this one increases the tax to 8 per cent on all salaries and wages paid in private employment, up to $3600 annually.

It contains the same compulsory factor; the same sugar-coated assertion of freedom of choice of physician, which turns out to be neither freedom nor choice; limitations on existing voluntary insurance programs that would soon render them innocuous; the same unrestricted domination by one man in its administration—the Surgeon General of Public Health; the same violation of physician-patient relationship through public records; the same old bureaucratic control; and in a word the assumption of the government that it alone offers security through control of the individual.

And who is back of all this? The social planners, working behind the smoke screen of political sponsorship, have developed this program and are utilizing the exigencies of war to force it upon the American people.

By actual proof we are the healthiest nation in the world. Under the American system—not under any foreign importation, but under the American system—American medicine, American doctors—we have developed the most effective and the most widely-distributed medical care that has ever been provided for any comparable number of people anywhere at any time.

What then will be the effect of the passage of such legislation upon our social life? What will be the effect upon the character and the enterprise of a generation which knows that from before its birth in a government hospital until it is laid away in the grave a benevolent governmental bureau will pay the costs of being born, pay the costs of its education, will supply its recreational needs, will provide medical services and hospitalization during illness, will provide an income during unemployment and sickness, and will give a pension if permanently disabled or retired by old age? What becomes of the incentive to rise above the conditions in which the individual is born?

It was free enterprise and determination that built this great country of ours and has sustained it throughout the years. And upon the concept of freedom, and not compulsion, I think it will manage to survive.

In the vast desert of human enterprise the weary toiler strains his eyes in search of the oasis of hope, strength, and security. Let him not be misled by the mirage of governmental medicine!

N. K. Foster

# APPEAL FOR RELEASE OF MEDICAL OFFICERS NOT NEEDED BY ARMED FORCES

The Executive Committee of the Indiana State Medical Association at its regular monthly meeting on June 17, 1945, authorized the publication and distribution of the following statement:

Now that V-E Day is passed and we are expecting the release from service of part of our armed forces, immediate consideration should be given to the release of as many of the doctors as is consistent with the best interest of the armed forces and of the civilian population. Promptness in reducing the size of the Medical Corps should be the positive aim of everyone having responsibility in this field. There should never be a time when any doctor is being kept in the military service with nothing for him to do professionally in connection with his military status. He should not be kept in the service to do things which could as well be done by those not trained as physicians. Many persons have delayed obtaining the medical care they should have had until their regular physicians get back from the war.

The doctors in the service have written a glorious chapter in the history of American Medicine. We point with particular pride to the record of the Indiana physicians who volunteered. Indiana was among the first states to fill its quota of medical officers. It never has lagged in filling any additional demands made upon the profession by the military authorities. The outstanding service rendered by these medical officers has merited rewards in every combat area where American troops have served and are serving. The Army, Navy, and Air Force should not incur the criticism of the public or of the physicians in those services by holding any physician in military service a day longer than the interest of the country requires.

The medical profession of Indiana was determined at the outbreak of the war that no one in the armed services of the United States should ever lack medical care, no matter how urgent and severe an emergency the armed forces might be called upon to face. Some of the public may have felt that this obligation of medicine to the armed forces was over-emphasized, to the disadvantage of the civilian population. A severe epidemic would have presented a real medical problem, and it is fortunate that this has not occurred, for many doctors who did not enter the service have carried professional burdens beyond their strength.

The Executive Committee of the Indiana State Medical Association urges that those in authority look upon the early and prompt release of physicians, when they can be spared, as a matter of utmost urgency and importance, — and when we say "when they can be spared," we must be understood to mean that every soldier, sailor, marine, nurse, WAC, WAVE, or SPAR, or anyone else who needs medical care in connection with military services will have it, even without the physicians who are to be dismissed. But after all the armed services are taken care of, any delay in releasing a physician should be avoided as an injustice to the public, an unnecessary burden on the treasury, a source of criticism of those in authority, and unfair treatment of the physician who is serving his country.

EXECUTIVE COMMITTEE

N. K. Forster, M.D., Hammond, *President.*
J. E. Ferrell, M.D., Fortville, *President-elect.*
F. T. Romberger, M.D., Lafayette, *Chairman of the Council.*
C. H. McCaskey, M.D., Indianapolis.
Cleon A. Nafe, M.D., Indianapolis, *Chairman.*
Thomas A. Hendricks, *Executive Secretary.*

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## ANNUAL NUMBER OF THE JOURNAL

Whether or not the Office of Defense Transportation will allow the Indiana State Medical Association to hold its regular annual session, which is scheduled for French Lick, October 2, 3, and 4, 1945, as usual the September issue of THE JOURNAL will be the annual number. In this issue the annual reports of the officers and committees are to be published.

If travel restrictions this year prevent an annual meeting, with the customary scientific program, a meeting of the House of Delegates probably will be held. If only a House of Delegates meeting is held, this meeting probably will be held at Indianapolis.

# FACTS DEVELOPED BY SELECTIVE SERVICE EXAMINATIONS

R. E. WYNNE, M.D.*

BEDFORD

The selectees I examined in connection with the Selective Service Examinations came from thirty-one different states; therefore, I feel that my experience is fairly representative of the country at large. To one with experience in examining the youth of a representative county of the midwest, it is easy to answer the question, "Why did we have so many 4-F's among the selectees?" My answer is based upon twenty-five years' experience as medical inspector for the city schools in Bedford. Add to this experience five years in The United States Public Health Service. While in this service I worked in West Virginia, Indiana, Maryland, District of Columbia, South Carolina, Georgia, Alabama, Kansas, and Wyoming. My hospital experience included one year at the Mercy Hospital, at Baltimore, and six months in St. Louis, Chicago, and New York City. These facts are related to show my qualifications on this subject. Finally, I served one year with the United States Coast Guard at New London Ct., during World War I.

As a member of the medical personnel for the Selective Service Board Number I, Lawrence County, Indiana, I served more than two years, and examined a large number of the men in this area. In the beginning there were so many dental defects found that the standards were lowered and dental care given after induction. Diseased tonsils and perforated eardrums took a large number off the list in the early part of the war. I should state that there was usually an associated arthritis in this group. Otitis media was still a cause for rejection when I examined the last group, before all local examinations were discontinued.

It is estimated, from the newspaper lists of those sent to induction centers, and later lists of those accepted, that there were from this area about 700 in the 4-F classification. It is also estimated that between 5,000 to 5,500 are in the Selective Service here. This is purely an estimated number, and in no way an official statement.

Concerning those with congenital defects which would be cause for rejection, I am not including in my estimate the number who had remedial conditions which could have been corrected by medical aid, among which I mean idiots, imbeciles, monsters, and those born blind.

Mental deficiencies, the psychopaths, I will mention because it seemed to me that there were too many here in that class. I have not seen figures for other parts of the country, so it is purely an assumption on my part. In this group were a few cases of goiter and anxiety neurosis. This latter group were amenable to improvement by surgery. Two obese boys 250-300 pounds showed imbalance of the endocrine system. Circulatory diseases did not carry as much weight in the cause for rejection in this war as it did in World War I. Those with evidence of decompensation were, of course, readily rejected. It did not come near the top in rejections.

Pulmonary tuberculosis was not considered because those cases were left for the induction centers and the x-ray examinations. Where there was a definite history of the disease or exposure in the family, it was, of course, noted on the induction sheet or examination blank. This limestone district runs rather high in tuberculosis; however, there are usually wide discrepancies in the report put out by the lay anti-tuberculosis society of this county. For some reason we are usually over our quota of patients at Silvercrest Sanitarium. The reports depend upon the time of year they are issued; the best ones come out when the money-raising campaign is about to get under way.

Defects of vision were quite prevalent, with some cases of blindness in one eye discovered for the first time as a result of the examination. Strabismus caused a number of rejections. Myopia and astigmatism corrected to normal or thereabouts were not rejected.

Gastro-intestinal defects were rare in my experience; I recall only four, all of which gave documentary evidence of surgery of the stomach—usually ulcer. Two of these were from out of the state (Arkansas and California).

Hernia was rather high, because I am including both the incomplete and complete hernia. I know several of these cases were discovered in early childhood, in junior high, and some in high school, and were urged to have them corrected long before we ever dreamed of another war. Some were excluded from approved athletics because of the hernia.

Varicoceles were not numerous, hydroceles were discovered in five cases, and varicose veins, the sacculated type, were encountered in about fourteen of the twenty-eight to thirty-six-year age group. One of the number submitted to treatment, and when he was cured the offer made him was withdrawn. To date he has not been called again.

Pes planus was not recorded except in those with marked pronation and rigidity, due to the highly-mechanized army of the United States.

Cryptorchidism was found in four cases. Of these, two had the testicles in the abdomen, and two had the testicles in the canal. One was finally accepted after repeated examinations and, of course, is making a good officer in the armed services. Cleft palate was found in only two, one of whom had submitted to surgery three times. He also had harelip. I encountered one case of ozena, due to congenital

*Coroner Lawrence County

lues. The ozena was discovered when he was in the primary grade, and the parents were informed of the condition, but would not make the boy take treatments. He was finally excluded from school because of the objectionable odor, and eventually was sent to the Riley Hospital for treatment. Cases of venereal disease were rejected in the beginning, but later on orders came through to re-examine and send them along. Those with tertiary lues were, of course, rejected here. Gonorrhea cases were easily cleared up with the newer therapy of today.

I do not want to appear to be a pessimist, or one opposed to public health. However, my experience with the public and my persistent endeavor to get defects corrected in early life convince me that something is lacking somewhere. People will spend plenty of money to keep an old, worn-out car on the road, but when it comes to the human body, for which we have no replacement parts at any time, they will procrastinate and tighten their purse strings. I refer to dental work, especially malocclusion and high arch palates—think of the numerous tonsillectomies which have been performed when dentistry was indicated! Speech impediment is frequently due to these conditions. Then, think of the hearing defects that could be prevented if diseased tonsils were removed more often. The attitude of the public and their dilly-dallying habits and indifference makes me appear a pessimist. If I did surgery and would personally profit by people following my advice, then there might be some reason for their procrastination. It has always been my policy to insist that the victim consult his family physician. Sometimes I wonder if the parents are cowards when it comes to surgery—I do not refer to the conscientious objectors (religious reasons). A great many parents dislike to make decisions for their children.

The public health program we follow here in our city schools has one outstanding example of effectiveness. For twenty-four years none of the schools have been closed because of epidemics, while nearby cities have been closed for a week or more due to epidemics. We are still carrying on public health activities, and as long as I am connected with the schools in this department we will keep abreast of the times. In my opinion state medicine will not correct these 4-F's of the future, unless there is absolute dictatorship and military supervision of the children from the ages of six to twenty-one years. We have had splendid cooperation by education and missionary work locally, but with all that intensive work, including a full-time registered nurse, P.-T.A.'s, and the dental and medical profession giving generously of their professional services, I suspect Lawrence County had as high a number of rejections as the average county. Many, yes very many, of the lads I examined I had known from the time of their first day in school up to the time they reported for induction. And many of them still carried the defects they were advised to correct years before; not for military reasons, but for the benefit of their health, and to add to their longevity.

Two years as director of the venereal disease clinic in Lawrence County further bears out the contrariness of the human race. We have efficient and well-trained registered public health nurses—I mean exactly what I say about their qualifications. They are good-looking, have pleasing personalities and plenty of tact, and notwithstanding all of this we too frequently have to resort to threats of quarantine, or the sending of the sheriff or police to get these unfortunate people to come to the *free clinic* for treatment. The physicians administering the treatment are well qualified for their duties. Yet with this utopian setup people will not take advantage of it as fully as they should. There is a fair degree of privacy in the clinic, especially as regards the help at the hospital. None are allowed in the basement during clinic hours, 4:00 to 6:00 P.M.

Years ago I thought the public would flock to free clinics, but now that I have passed the meridian of life I am convinced that there must be some "mule" qualities in too many of us. Perhaps I should say to these advocates of state medicine, "The ass I leave with you while I and the lad go yonder to worship" (Genesis 22:5).

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## ABSTRACT

### FIND DRUG EFFECTIVE IN RELIEVING ANGINA PECTORIS PAIN

Thiouracil, a drug widely used in recent years for the treatment of toxic goiter, has proved effective in a small group of patients by relieving pain associated with angina pectoris, a common form of heart disease associated with pain, according to preliminary studies reported in the May 26 issue of *The Journal of the American Medical Association.*

Wilhelm Raab, M.D., of the University of Vermont College of Medicine, Burlington, Vermont, says that thiouracil medication proved effective in seven out of ten patients with angina pectoris. In four cases, three of which were severe, the symptoms disappeared entirely during the treatment.

Dr. Raab explained that the treatment which is similar for goiter and angina pectoris has much the same effect in both conditions since the maximum improvement in heart patients was reached when the basal metabolic rate had fallen seven to twenty-seven points below its pre-treatment level. The thiouracil also acts to reduce the metabolic rate in goiter patients.

The Vermont College physician cited the case of one man, aged seventy, who suffered from attacks of severe heart pain under the breast bone for three years. The pain persisted usually for about five minutes, and at times he could not walk farther than fifty feet without stopping. Thiouracil was given in two periods of four months and five months, respectively. During the first period the attacks disappeared within one month, except for two more isolated attacks, and during the second period three weeks elapsed before the attacks disappeared completely. The patient has since been able to walk and climb hills at a fast pace without any discomfort.

# GROUP MALPRACTICE INSURANCE AND HEALTH AND SICKNESS INSURANCE*

DON C. HAWKINS

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INDIANAPOLIS

The subject of malpractice is of great importance to the medical profession, and the large number of cases brought annually in each state should be a warning that their professional reputation and earnings are in jeopardy. The maxim "an ounce of prevention is worth a pound of cure" has special application in this case, and yet how can the medical profession prevent the calamity of a malpractice suit if they are in no way informed of the principles which govern their conduct in the treatment of patients?

There are certain well-defined principles which should not only be known but felt, and they should become a part of the equipment for the work to be performed. Each individual should understand that with his privileges he assumes certain duties, and he should understand what these duties are, and have them in mind as he goes about his daily work.

There is no better way to avoid mistakes and errors than to know the mistakes and errors which have caused other members trouble and expense. It is well known that human beings ordinarily are responsible for their own careless action, and also responsible for the negligent harms inflicted by their agents and employees. It should also be understood that under our constitution questions of fact and civil cases are usually tried by a jury, and, as a general rule, the jury is composed of individuals untrained in scientific knowledge. This fact in itself should impress one with the necessity of exercising such a degree of care as will appear to the layman as being reasonable. They weigh only the evidence in the case, and unless the plaintiff introduces some evidence that the injury complained of was caused by negligence, or that the treatment was not proper, the court will not allow the jury to pass on a case no matter how unfortunate the results of the treatment may be. The rules of law governing these cases are not statutory nor local. They are the principles of common law applicable and enforceable in every state in the union.

In a recent case in a southern state a doctor instructed the operating-room supervisor, who, in turn, instructed an operating-room nurse to prepare the tray with a solution of 1 per cent novocaine. The nurse states that she understood the supervisor to say "cocaine." The doctor filled his one-ounce injection needle, which was introduced into the tonsils. The throat immediately became paralized, convulsions set in, and the patient died in a few minutes. The nurse had prepared one ounce of 5 or 10 per cent cocaine.

In another case recently-reported injuries were sustained by a child fifteen months old, who had entered a hospital for an eye operation. The doctor employed by the hospital applied a tourniquet on the upper arm, at approximately 3:30 P.M., on the fourth of the month, in order to take a Wassermann. He forgot it, and the tourniquet was not removed until 4:30 P.M., on the fifth. The result was that the child has lost all use of the arm below where the tourniquet was applied.

There are numerous cases of carelessness and negligence which can be avoided, and the program which has been instituted in Indiana was formulated on a basis which is both preventive and remedial. It aims to reduce accidents and causes for damage suits, as well as to provide better protection to the individual members of the society when a claim occurs.

In many states the number of claims and their size have been increasing, and the loss experience of some insurance companies writing malpractice insurance have been steadily mounting. In many cases losses have been more than 200 per cent of the total premiums paid. Obviously, insurance companies cannot continue to write this type of business under those conditions, unless premiums are extremely high, and this high loss experience is due to several causes. One of the most important causes, probably, is the changing attitude of the courts. They increasingly trend to exact from individual members of the medical society, as well as non-profit hospitals, the same responsibilities that are exacted from other types of enterprise, and whether this attitude is socially desirable is a broad question involving many factors. The important thing to the medical profession is that the change of attitude is already a fact.

This attitude as yet has not been noticeable in Indiana, and we hope that this plan will in somewise prevent it. The second important element increasing losses is the growth of actual racketeering in damage claims, and, in less extreme cases, the development of a tendency to use a damage claim as a method of avoiding payment of medical expenses. Certain notorious lawyers regularly accept such claims on a contingent fee basis, and each time a physician loses a case other cases are encouraged. Another factor that encourages suits is that insurance companies have too often been willing to settle unjustified claims out of court for their

* Presented before the Secretaries' Conference of the Indiana State Medical Association, at Indianapolis, on January 21, 1945.

nuisance value. When an unjustified claim is settled out of court, that is the greatest possible encouragement for other persons with perverted morals to try the same trick.

The plan to which I refer, which has been approved and recommended to the medical profession of Indiana, in brief is as follows: the company is prepared to issue individual policies through regularly-licensed and accredited insurance agents and brokers on a broad-form, full-coverage public liability policy. The policy is available only to members in good standing of the Indiana State Medical Association. Each risk is to be underwritten separately, and the company is to use its own judgment in accepting and rejecting risks—the reason for this being obvious. For example, in most state associations there are members who should not be privileged to hold membership in a county or state society, and by investigation it is possible, in cooperation with the state society, to determine which members are a detriment to the county and the state society. There is no requirement as to a fixed percentage of the membership which must insure under the plan, for it is entirely voluntary with the individual physician whether or not he desires to become insured.

There is a definite known rating formula as to the cost to each individual member of the society, irrespective of the nature of his practice. The policies will be written for any limit the doctors may desire, on a one-, three-, or a five-year basis. As soon as the plan has been in effect a sufficient length of time to enable the company to gather the necessary experience, there will be an adjustment in the premium charges. Confidential bulletins will be issued, presenting to the association typical claims which have been sustained with particular attention to means of preventing accidents and minimizing conduct prejudicial to legal defense of such claims. The company is committed to work very closely with the existing defense counsel of the state association, Mr. Stump, who together with your Executive Committee has full knowledge of the development of this program, which we feel will eventually reduce your malpractice cost, and we will welcome your criticisms and suggestions as the plan progresses.

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# HEALTH EXAMINATIONS OF HIGH SCHOOL BOYS*

ELMER W. WEBER, Ed.D.†

EVANSVILLE

Much has been written about the lack of physical fitness among the young men of military age of our country. The situation preceding our entry into World War II was not altogether the fault of these young men. It is the result of apathy and indifference on the part of the government, state, municipalities, parents, teachers, churches, the medical and dental professions, and the public health associations. We might add that a great deal of this failure may be attributed to our educational system and the home. However, it is unjust to say that the fault lies entirely with our educational system, as some people have proclaimed.

After analyzing the causes for rejection of our young men we find that high on the list of causes are mental deficiencies and deviations. In the case of deficiencies — feeble-mindedness — we certainly cannot blame this upon the schools. We also find mental deviations from the normal—psychoneurotics and psychotics. In addition, we find young men whose mental reactions are unstable and somewhat deviated. These cases are to a great extent due to causes wholly outside the school. They may be attributed to hereditary or environmental factors over which the school has little control. The results of the physical examinations also reveal that a large number were rejected because of the effects of poliomyelitis, diabetes, hernia, rheumatic fever, faulty vision, and defective hearing. What could the schools do to prevent or correct any of the above-mentioned physical defects?

Another common enemy of mankind found among our selectees was tuberculosis. The public schools give an extensive educational program concerning tuberculosis, from the first through the twelfth grades, respectively. If the students and parents do not comprehend and practice tuberculosis prevention and cure, how can the schools be blamed?

Another interesting phase of the analysis of rejected selectees shows clearly that the longer a man has been out of school, the higher the rejection rate in nearly all categories. It will take the combined efforts of all interested in youth to bring about a cure, or what may be termed more important—prevention.

We all know that the Allies won World War I, but not until in September, 1939, did we begin to realize that we had lost the peace. Even then many thousands of people in our country were not concerned about the war. After the invasion of Poland, the low countries in Europe, and the fall of France in the spring of 1940 many people felt that our natural barriers, the Atlantic and the Pacific

* Presented before the Vanderburgh County Medical Society, December, 1944.

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oceans, were enough to keep us out of the war. It is true that only after the fall of France and after Germany had overrun practically all of Europe did we realize the seriousness of the war in Europe. Legislation was passed by Congress, calling for all men between the ages of twenty-one and thirty-five to register for the draft. This machinery was set in motion in October, 1940, but it did not call for men to leave the confines of our United States; it was only for national defense. Through Lend-Lease and other acts of Congress we were indirectly engaged in war, but it was not until the sneak attack on Pearl Harbor, December 7, 1941, that we, as a nation, became cognizant of our responsibilities and the danger of our future. The draft age was changed to include men up to the forty-five-year age group. The Selective Training and Service Act of 1940 was amended and became effective November 14, 1942, for eighteen- to nineteen-year-old registrants.

During these many months, while we were not directly at war, thousands of young men were examined. Of the first 2,000,000 examined 1,000,000 were rejected. Twenty-nine million men were between the ages of eighteen and forty-five, but only 22,000,000 men, those between the ages of eighteen and thirty-seven years of age, were subject to induction.

Since our entrance into the war the ages of inductees have been changed many times. It took time and experience to tell our leaders that the younger men would make the best soldiers. Not only in this lower age bracket did deficiencies, disorders, disabilities, defects, and disease abound, but these men were found to be soft, flabby, pampered and in need of physical conditioning. It was necessary for our armed forces to set up physical-conditioning programs at every training base after the men were inducted into the service. This represented weeks and months of wasted time. Our biggest and strongest enemy in this war has been—and still is—time, and yet we were required to spend a great deal of valuable time getting our fighting men into physical condition before they could be taught the present-day tactics of warfare.

The purpose of the physical fitness examination of our high school boys was different from that conducted by the armed forces. The purpose of our examinations was to determine whether or not the boy was physically fit to participate in the strenuous physical-conditioning program in school. Physical defects were found, but many of them were remediable defects and were not serious enough to disqualify the boy from the physical-conditioning program. Some of the defects found were serious enough that they did disqualify the boy from the armed forces, but not from the physical-conditioning program. Therefore, in comparing these two types of examinations it must be borne in mind that the primary objectives of these examinations were not the same.

As stated by J. Roswell Gallagher, M.D., and Lucien Brouha, M.D.: "There are three kinds of physical fitness: first, static or medical fitness, which is concerned with the soundness of the organs of the body; second, functional or dynamic fitness, which has to do with the efficiency of the body in strenuous work; and third, motor skills fitness, which is related to muscle coordination and strength in performing specific activities. A discussion of these three types of fitness is important, not alone for describing methods and results of testing them and indicating which procedures and programs may be of value in improving the level of man's fitness, but also for emphasizing that a many-sided attack is essential. Fitness cannot be evaluated by means of a conventional medical examination alone; the latter appraises the quality of the organism at rest, can separate the sick from the healthy and segregate those having organic defects from those without them, but does not reveal functional capacity. In short, such an examination does not provide a complete answer to the question of the examinee's condition and does not clarify normal, healthy individuals into various groups according to their physical efficiency. But even now physical fitness is too frequently discussed in terms of only one of its various components, and many panaceas and programs are proposed which although proper in themselves are no more than single items in a well-integrated and complete plan. Medical fitness, which is estimated by the conventional examination, must be considered first because it is fundamental.

"Not merely in times of war are such health examinations essential; this truism is mentioned here because the relation between good health and efficient day-by-day work is so obvious that it is often disregarded. Frequently there is failure to discriminate between a state of being well and a state of optimum health; too often it is felt that the increment between the two is not worth the time and effort involved. The importance of following the medical examination by the correction of any discovered defects cannot be too strongly emphasized. The efficiency of such examinations should be judged not by the percentage of defects found, but by the number of these defects subsequently corrected."[1]

In this discussion physical fitness will be referred to the first of the three kinds of physical fitness, that being the static or medical fitness, which is concerned with the soundness of the organs of the body. In our large physical-conditioning program in the high schools the other two kinds of physical fitness are stressed.

In the summer of 1942 a meeting was held in Washington, D.C., consisting of high-ranking Army and Navy officials, members from the United States Office of Education, and State Superintendents of Public Instruction. The purpose of this meeting was (1) to make plans for the physical, medical

[1] J. Roswell Gallagher, M.D., Lucien Brouha, M.D., "Physical Fitness, Its Evaluation and Significance," *J.A.M.A.*, **125**:834-838, (July 22) 1944.

and dental examination of all junior and senior students, and others sixteen years old or older, in high schools; and (2) to inaugurate in the high schools a physical fitness program for these students.

In December, 1942, arrangements were made through the cooperation of the Health Department of the Evansville Public Schools, the Vanderburgh County Medical Society, and the high school administrators and faculties to have every high school boy in the junior and senior classes, or those sixteen years old or older, given a thorough medical, dental, and physical examination.

The purpose of the health examination was threefold: (1) to determine whether or not a boy was physically fit to participate in the new strenuous physical-conditioning program; (2) to determine whether or not a boy had any remediable physical defects that would disqualify him from service in the armed forces; and (3) to bring about the correction of remediable defects as soon as possible. Each boy's physical education program was predicated upon the findings of the medical, physical, and dental examination.

The health examination conducted in the high schools was approved by the Executive Committee of the Indiana State Medical Association, the State Department of Health and Physical Education, and the Vanderburgh County Medical Society. It conforms very closely to the examination given to selectees before induction into the Army, Navy, or Marines.

The cost of the health examination was one dollar for each boy. Prior to the examination it was thought that this might hinder the program, but such was not the case. After the details of the health examination were explained to the boys, the faculties of the various high schools, and the Parent-Teachers Associations, including the methods and procedures to be used in conducting the examinations, the boys responded wholeheartedly. None of the fee was retained by the schools; it was turned over to the Vanderburgh County Medical Society to be distributed to the doctors participating in the examinations.

Committees were organized in each high school for the purpose of administering the examinations. The examinations were conducted in the gymnasiums of the various high schools each Thursday afternoon between the hours of 1:00 and 4:30. Due to the large number of boys participating in the program it was of paramount importance that examinations be held simultaneously in two high schools each Thursday. The medical personnel selected by the Vanderburgh County Medical Society consisted of a team of ten or twelve specialists and a dentist.

The health examinations were conducted in the gymnasiums via the station method. At each station there was a physician who examined each boy according to his specialty. Upon entering the gymnasium the boys were stripped to the waist. When they reached Station 5 they removed all their clothing and placed them on the chairs until they had finished being examined at Stations Nos. 5, 6, and 7. They were then instructed to put their clothes on and to proceed to Stations 8 and 9.

Before entering the examining room, or gymnasium, each boy was given a health examination sheet on which he had filled out his health history. The boy took the form with him to Station No. 1. After his examination he gave it to a clerk who assisted in recording the doctor's findings. The clerks were boys, chosen by the physical education instructor in each school, and who had previous instruction in their duties. When the findings of the particular doctor had been recorded, the clerk returned the health form to the boy, and he proceeded to Station No. 2, where the same procedure was followed. This was repeated until each boy had been examined by the doctor at each of the designated stations. If any doctor found a physical defect that would disqualify the boy from the physical-conditioning program, he signed the health examination form and explained the defect. If no defects were found that would disqualify the boy from the physical-conditioning program, the doctor who last examined the boy signed his name, stating that the boy was physically fit. The boy then took the health form to the school nurse-teacher and she recorded the findings and checked the defects with a red pencil.

In January, 1943, one thousand fifty-four boys were examined. The findings indicated that only seventy-seven boys, or 7 per cent, were found to be physically unfit to participate in the strenuous physical-conditioning program. The most prevalent physical defects which disqualified them were heart conditions and hernia. Many boys were found to have remediable defects, but none of these were flagrant enough to prohibit participation.

In September, 1943, only the junior boys were examined. The same methods and procedures were used as were used in January, 1943. Four hundred thirty-two boys were examined, and twenty-one, or 5 per cent, were rejected. Reasons for rejection were: heart, hernia, lung, results of infantile paralysis, diseased hip, inguinal cryptodidymus, strabismus, and glandular condition.

The Health Department of the Evansville Public Schools realized that greater emphasis should be placed on physical fitness during the school year 1944-1945. For this reason the health examination was changed considerably. Through the cooperative efforts of the Vanderburgh County Medical Society it was decided to give every boy in the high schools a physical, medical, and dental examination rather than just the junior and senior boys. Since every boy in the high school was participating in physical education activities five days a week, one hour a day, it seemed that this was the logical thing to do. This forward step conforms with the ideas of the Committee on Physical Fitness of the Federal Security Agency, which is in keeping with its established policy of working through exist-

ing agencies, which recently enlisted the support of the American Medical Association in the National Fitness Program.

Because of the increased number of boys to be examined, it became apparent that more doctors would be needed to perform this all-important task. However, the Vanderburgh County Medical Society responded nobly. In order to complete these examinations in all the high schools it required four Thursday afternoons, with a team of doctors, consisting of from twelve to fourteen, working simultaneously in two of the high schools each week. This year two thousand forty-one boys were examined during the four-week period. Only one hundred five boys, or 5 per cent, were rejected from participating in the strenuous physical-conditioning program.

Each of these boys was given an audiometer test each fall by the nurse-teacher in the high school. The Vollmer Patch Test was given to all junior students and athletes each year. All positive reactors were x-rayed by the Vanderburgh County Tuberculosis Association Mobile Unit. No active cases of tuberculosis were found.

The original copy of the health examination form is retained by the nurse-teacher in each of the high schools. This form is filed with each boy's cumulative health record in the office of the nurse-teacher. The names of boys and the respective physical defect of each are given to the health and physical education instructor and the home room teacher. This is done in order that follow-up work may be conducted by these people. A letter is sent to each parent by mail, telling of the findings of the examination and recommending that the remediable defect or defects be corrected as soon as possible.

**DEFECTS FOUND DURING PHYSICAL FITNESS EXAMINATIONS CONDUCTED IN THE EVANSVILLE HIGH SCHOOLS, SEPTEMBER 7 TO 28, 1944**

| | *Seniors* | *Juniors* | *Sophomores* | *Freshmen* | *Total* | *Per Cent* |
|---|---|---|---|---|---|---|
| Number examined | 295 | 465 | 503 | 778 | 2041 | |
| Non-smallpox* | 68 | 129 | 180 | 155 | 532 | 26.0 |
| Non-typhoid** | 177 | 279 | 347 | 453 | 1256 | 61.0 |
| Eyes: | | | | | | |
| Blepharitis | | | | 1 | 1 | |
| Conjunctivitis | 2 | 1 | 5 | 2 | 10 | |
| Trachoma | | | | 1 | 1 | |
| Strabismus | | | 1 | | 1 | |
| Amblyopia, right eye | | 1 | | | 1 | |
| Traumatic injury, left | | | 1 | | 1 | |
| Injury blindness | | 1 | | | 1 | |
| Vision | 30 | 37 | 35 | 78 | 180 | 9.0 |
| Ears | 7 | 27 | 7 | 15 | 60 | 2.4 |
| Nose | | | | | 273 | 13.0 |
| Chronic sinus infection | 8 | 11 | 8 | 10 | 37 | |
| Polyp | 2 | 4 | 2 | 3 | 11 | |
| Perforated septum | 2 | 8 | 5 | 6 | 21 | |
| Deflected septum | 39 | 40 | 61 | 64 | 204 | |
| Throat | 80 | 138 | 101 | 176 | 495 | 24.2 |
| Teeth | 150 | 281 | 252 | 420 | 1103 | 54.0 |
| Circulatory | 4 | 7 | 15 | 28 | 54 | 2.6 |
| Lungs | 4 | 10 | 2 | 7 | 23 | 1.12 |
| Abdomen | 2 | 3 | 3 | 3 | 11 | .5 |
| Hernia | 5 | 6 | 4 | 13 | 28 | 1.3 |
| Genito-Urinary | 27 | 46 | 24 | 36 | 133 | 6.5 |
| Varicocele | 10 | 18 | 10 | 9 | 47 | |
| Prepuce | 6 | 16 | 4 | 16 | 42 | |
| Hydrocele | 6 | 3 | 1 | 3 | 13 | |
| Infantile genitalia | 5 | 8 | 8 | 7 | 28 | |
| Atrophy of right testicle | | 1 | | | 1 | |
| Atrophy of left testicle | | | 1 | | 1 | |
| Undescended testicle | | | | 1 | 1 | |
| Anorectal | | 3 | 3 | 2 | 8 | .4 |
| Nervous and mental | 5 | 4 | 3 | 5 | 17 | .8 |
| Skin | 4 | 5 | 7 | 10 | 26 | 1.2 |
| Orthopedic impairments | 17 | 21 | 16 | 16 | 70 | 3.1 |
| Flat feet | 12 | 2 | 7 | 35 | 56 | 2.6 |
| | 653 | 1092 | 1098 | 1554 | 4401 | |

* Boys who had not been vaccinated within the past seven years.
** Boys who had not been inoculated for typhoid within the past three years.

CONCLUSION

1. The annual physical examination is educational to each boy.
2. It is the best means for detecting remediable defects which are in their early stages.
3. The results of the examination may be used by instructors in health classes.
4. The physical fitness examination is instrumental in determining a boy's physical education program.
5. The findings of this examination compare favorably with similar examinations given elsewhere.
6. It reveals to the parents the remediable defects that need correction.

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# GROUP HOSPITAL AND SURGICAL INSURANCE PROVIDED BY THE INDIANA FARM BUREAU

JACK J. ROSEBROUGH*

INDIANAPOLIS

Agriculture is America's biggest business. Yet the farmer is a rugged individualist. His closest hospital and medical aid is often miles away. Consequently, his approach to the solving of this all-important need for medical care has been in an individualistic manner.

While the urban employee has had the benefits of group insurance for many years, the farmer has not had the opportunity to participate in similar plans. Recognizing, however, the great need for a realization on the part of the farmer that a hospital was a haven to which he should come in the event of illness, and do it quickly, and knowing that by entering the hospital he immediately became more accessible to the great staff of physicians and surgeons who are available to the urban population, The Indiana Farm Bureau, Inc., embarked upon a group hospital and surgical benefit policy in 1943. This is the first group plan of insurance ever offered to the farmers in Indiana, and it is being done through the Farm Bureau membership in the county associations.

The Indiana Farm Bureau, Inc., has among its affiliated groups a legal reserve mutual life insurance company (non-assessable). This company, The Hoosier Farm Bureau Life Insurance Company, is the carrier for the group hospital expense and surgical policy being made available through the County Farm Bureau Associations. This is a prepayment plan of insurance and provides the following benefits: The hospitalization portion of the contract is on a per diem basis with five dollars per day allowed for male adults, and four dollars per day for adult females and dependents. Dependents are the unmarried children, from three months to eighteen years, inclusive. The maximum for any one hospital confinement is thirty days. Special charge allowances are made equal to five times the daily benefit. These special charges cover such items as operating room, laboratory, x-rays, delivery room, anesthetics, administration of anesthetics, et cetera. The surgical benefit portion of the contract is on an indemnifying basis according to a prescribed schedule. For example, for an appendectomy we allow up to $100.00. In the event the surgeon does the operation for $90.00, we would pay the $90.00. If the surgeon's fee is $150.00, we would allow $100.00. Another example of surgical allowance is that of a thyroidectomy for which the maximum allowance is $150.00. A full surgical schedule is allowed for females and dependents. The monthly premium for the hospital expense and surgical allowances is $1.20 for males, $1.20 for females, and $1.00 for all dependents. In other words, a complete family pays a premium of $3.40 monthly. This covers father, mother, and all unmarried children between the ages of three months and eighteen years.

It is recognized that certain items could be strengthened. However, the field is certainly still in the experimental stage, and consequently the present program is not necessarily the best that can be offered in the future. It is at least a good start in the right direction. The Hoosier Farm Bureau Life Insurance Company is owned by its policyholders, and naturally the rates will be only those required to meet claims, pay expenses, establish safe contingency reserves, and any excess charge will be refunded to the insureds.

The farmer, with his rugged individualistic viewpoint, certainly is very antagonistic toward socialized medicine, but is eager to participate in a plan of prepayment hospital and surgical expenses. The Indiana Farm Bureau, Inc., shares this opinion, and consequently is most anxious that the group plan progress so that state-wide coverage may be offered.

* Acting general manager of The Hoosier Farm Bureau Life Insurance Company.

# Military News

The miraculous survival of the *U. S. S. Franklin* and the gallantry of her officers and men will go down in history as one of the outstanding sagas of this war. Indiana Medicine is justly proud to have been represented by Lieutenant Commander James L. Fuelling, who was singled out for special commendation and recommended for the Navy Cross or the Congressional Medal of Honor for his part in the triumph over one of the severest ordeals of the war.

*Lt. Com. J. L. Fuelling*

Commander Fuelling, who was the assistant flight officer aboard the "Big Ben," as she was called by her personnel, was one of the hundreds of men who were trapped below deck when the first explosion blasted the ship. He calmed the men, and all but one later managed to escape through some ventilation tubing. His part in reducing casualties when the ship became a holocaust has placed his name high on the list of Navy heroes.

At the time the tragedy was officially announced by the Navy Department, Commander Fuelling was at home on leave in Indianapolis before reporting to the Bunker Hill Naval Air Station, which was his new assignment, and with which he was very pleased. However, he is quoted as saying, "I don't know whether the shore duty is for six months or for the duration, but if I get sea duty again, I'd like to get it on the 'Big Ben'—when she gets well."

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Captain John J. Flick, of Indianapolis, has gone overseas with a general hospital. His former station was Patterson Field, Ohio.

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After being stationed in Iran for almost three years, Major L. M. McNaughton, of Petersburg, has returned to this country, and has been home on a forty-five-day leave.

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"Yes, I'm going out again, and this time in charge of a hospital," is the message accompanying a change-of-address from Captain John R. Phillips, of Michigan City, who was at the Naval Advance Base Personnel Depot, at San Bruno, California, but who now has a San Francisco A.P.O. address.

Major Harry L. Kahan, of Gary, is now stationed at the Jefferson Proving Ground Hospital, at Madison, Indiana.

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Dr. George F. Green, of South Bend, has been promoted from major to lieutenant colonel. Colonel Green is on duty in England.

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Word has come to this office that Captain J. L. Larmore, of Muncie, is now on duty with a general hospital located in Burma.

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Two Kokomo doctors, Major Richard P. Good and Lieutenant Marvin P. Cuthbert, are on duty at the eye, ear, nose and throat clinic at the Vaughn General Hospital, at Hines, Illinois.

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Lieutenant Bennett W. Thayer, of North Vernon, has been detached from his former post, to report to the west coast for his second tour of duty in the Pacific. For the past several months he has been stationed at Houston, Texas. During his first tour, which lasted fifteen months, Lieutenant Thayer was stationed on Midway Island and at Pearl Harbor.

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According to a newspaper report, Major J. M. Kirtley, of Crawfordsville, has been awarded the Bronze Star for gallantry displayed in action on D-Day, and later received the Oak Leaf Cluster for heroic work in the Hurtgen Forest in Germany. Major Kirtley is a regimental surgeon with the Fourth Division.

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Major John W. Graves, of Indianapolis, now in Washington, D.C., writes: "I spent almost two years in the Office of the Surgeon General, and on November 8, 1944, I was reassigned to the Office of the Secretary of War." He says he will be glad when the Hoosier "Docs" can return to their practices. (Major Graves, we hope that day may soon be here.)

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As chief surgeon with a fleet hospital which he helped to plan, Lieutenant Commander Charles C. Terry, of South Bend, is often "put to it" to provide adequate service for the large number of wounded which they receive. This hospital receives all Navy and Marine casualties from the Pacific area and distributes them as rapidly as possible to hospitals near their homes, retaining about eight per cent of each convoy for further treatment. Because of the lack of sufficient operating room space, the forty-seven medics, most of whom are surgeons, are working day and night shifts.

From the Mediterranean Theatre we have received the following information: First American surgeon in the war to come to Corsica in the early days of the Mediterranean campaign, Major John M. Palm, of Brazil, Indiana, has now been assigned as assistant flight surgeon for a Mediterranean-based B-25 Mitchell medium bombardment wing, after serving more than a year and a half on the French island.

*Major John M. Palm*

At present Major Palm is working with Lieutenant Colonel Robert R. Pinger, flight surgeon for the Mitchell B-25's, on a program for attaining maximum number of combat missions by B-25 personnel without harm to the individual.

Their emphasis upon individualization, combined with a system of rest camps, recreation, and improved living conditions has made it possible for the average airman to fly more missions without harm to himself or impairment of his combat efficiency. Length of each mission, opposition encountered, weather, type of target, and the airman's physique and emotional make-up are all considered in determining how many missions he will be expected to fly, according to Major Palm.

Major Palm went overseas in March, 1943, and has seen service in French Morocco and Algeria. He is authorized to wear the European-African-Middle-East campaign ribbon with three battle stars.

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After serving for a while in a modern Chinese hospital, Major Wendell L. Spalding, of Mishawaka, has moved on, and is now serving with a tank group of the Chinese Army. Major Spalding is accompanied everywhere by a Chinese major, who also acts as his interpreter.

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With a station hospital on Guadalcanal, Major Leo L. Grzesk, of South Bend, recently had the privilege of pinning the Purple Heart on the many patients there to receive them. Many of the boys were flown there from Guam, Saipan and the Marianas. In addition to military installations on Guadalcanal, the government also has an army of farmers there, and the land is well cultivated. They grow celery, lettuce, tomatoes, radishes and all types of melons. Potatoes and the solid-type vegetables will not grow there. They also have some cattle, but they do not thrive, and consequently the meat is not good. All of this, as a part of the Army, is rather surprising.

Major John L. Sharp, of Crawfordsville, was one of the 101st Airborne Division's few medical officers during the historic siege of Bastogne. Major Sharp has been attached to the 101st Division since August, 1944.

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Dr. Robert L. Amos, of Newcastle, who is the head of the urological section with the Indiana General Hospital, has recently been promoted to a major.

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Dr. Kenneth H. Brown, of New Albany, has also been promoted to major. For the past eighteen months Major Brown has been attending surgeon at the station hospital at Camp Polk, Louisiana. The hospital has recently been designated as a regional hospital.

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A reunion of three Anderson physicians, who have been friends since boyhood, took place recently in the Philippines, where all are stationed.

The meeting occurred on Leyte when Lieutenant Francis M. Williams, a Navy doctor on duty with a Marine fighter squadron, came from a nearby airfield to borrow an ambulance, and "discovered" Major Eugene W. Austin, flight surgeon for a bombardment group. Only a few days before, Major Austin had met Captain William N. Jones, who is on the staff of a general hospital based only twelve miles away. Shortly thereafter the three had a get-together dinner, with the Navy supplying some real steaks, but we would be willing to bet that the best part of the evening was the exchange of experiences—both recent and old.

Lieutenant Williams has been overseas four months, and Captain Jones has been stationed for two years near Sydney, Australia, having arrived overseas in May, 1942. Major Austin arrived in New Guinea in December, 1942, and was stationed at Port Mosby for almost a year. As fast as the Japs were cleaned out of the north coast, Major Austin's group was moved forward. At his last three stations, Hollandia, Biak, and Leyte he has been responsible for the establishment of a station hospital. Major Austin is now in Manila.

*Major Austin, Lieutenant Williams, and Captain Jones*

Lieutenant M. Richard Harding, of Indianapolis, who recently received a commission in the Army, is now at Carlisle Barracks, Pennsylvania.

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Formerly at a dispensary in New Guinea, Lieutenant Colonel John Lansford, of Redkey, is now at the Harmon General Hospital, Longview, Texas.

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Captain Richard K. Schmitt, of Columbus, formerly at New Caledonia and Guadalcanal, is now an instructor in the WAC Medical Technicians School at the Wakeman Hospital Center.

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In a letter from Major Carl J. Rudolph, of South Bend, he stated that he was in the hospital with an attack of pneumonia. For the past five months Major Rudolph has been stationed in Paris as chief of the EENT section of the 202nd General Hospital.

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After thirty-three months of service overseas Captain Kemper N. Venis, of Muncie, has been home on a thirty-day leave. On duty with an evacuation hospital, he has been stationed at North Africa, Sicily, France, Belgium, and Germany. In the Belgian Bulge last December the Germans came within six miles of the hospital. Captain Venis says that although it was actually the town they were shelling the hospital was hit, but fortunately casualties were very low. Not only has the medical staff worked in the midst of bombings, but also under dogfights between Allied bombers and German fighter planes. Captain Venis was chief anesthetist and worked usually twelve to fourteen hours a day, and quite often even longer hours. In addition to other campaign ribbons, he is authorized to wear "the little arrowhead" which designates an initial assault landing and is wearable only by men who have ridden to the beaches on landing craft, or for men of the airborne divisions.

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Two Indianapolis physicians have been awarded high military decorations for performance of outstanding medical work as members of an air force in Italy.

Major George M. Brother, assistant surgeon at the headquarters, has been awarded the Bronze Star for developing an extremely effective malaria-control program. He was assistant state health commissioner before entering the Army in December, 1942.

The Legion of Merit has been presented to Captain J. H. Gosman, of Indianapolis, flight surgeon, for the development of an electrical headset for the treatment of ear trouble among combat fliers. This headset has shortened the period of treatment from three to five days. He has also been cited for his work in the fields of sanitation and immunization. Captain Gosman was a resident in surgery at the Indianapolis City Hospital before entering the Army.

A visit to the Buchenwald Concentration Camp where, not counting the executions, two hundred to four hundred prisoners died daily, was described so vividly in a recent issue of the *Indianapolis Star* by a medical officer that we wish to quote it in part herewith: "Through crowds of pale, emaciated, ghostlike men from all countries of the continent (mostly Poles and Russians) we were ashamed and almost afraid to stare into the faces of these starved men who had been robbed of their dignity and treated like animals. We found that the people of Weimar knew all about the camp, and even helped to capture escaping prisoners. The people in town appeared well-nourished, and seemed to have everything. You can imagine our loathing of the Germans as we see them on the roads and streets."

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We were pleased to receive a letter from Major A. G. Blazey, of Washington, who states his location simply as "Port of San Francisco":

"It is now more than a year ago since I last wrote you expressing appreciation for the frequent contact with home activities via the 'MedSoc' and THE JOURNAL—truly, it is a pleasure to read about your activities back in Indiana, particularly the way you are holding the legislative line.

"It is now almost two years since I started this duty as transport surgeon in the European theatre. We came into Pacific waters in March, 1944, and have been stuck here since. My 'leaves' last year were spent on one of the islands, referred to before the war as a tropical paradise. So far I have not been able to discern anything heavenly about the dozen islands I have visited, including some atolls.

"The Hoosier State is going to please me mighty well when I return."

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*Left is left, and right is right, but even though the arrows point in opposite directions there is no question which way Captain John R. Haslem is heading. The sign reads "7,969 miles to Terre Haute," and it is a sign we can all understand, for "This is America!" Captain Haslem is in the surgical service of Indiana General Hospital No. 32, now stationed at Aachen, Germany.*

Dr. T. M. Conley, of Kokomo, was commissioned a lieutenant in the United States Navy on May seventh.

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Dr. John E. Owen, of Indianapolis, has been promoted to the rank of colonel, and is on duty as chief of surgery at the Valley Forge General Hospital, at Phoenixville, Pennsylvania.

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Major Ernest R. Barnett, of Terre Haute, who was in his second year of internship at the Indianapolis City Hospital when he entered service, has returned from the Southwest Pacific and is now stationed at the Wakeman Hospital Center as an instructor at the Technicians' School.

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Formerly serving with one of the squadrons in the group, Dr. Harold E. Ropp, of New Harmony, has recently been promoted to major and placed in the position of senior flight surgeon of a troop carrier group. This group has figured prominently in operations in France, Holland, and in the relief of the beleaguered Allied forces in the Bastogne area. They have been awarded the Presidential Citation for their immeasurable contributions to the Normandy successes last June.

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Captain W. J. Fuson, of Greencastle, arrived from England on a ten-day leave after being overseas fifteen months. Captain Fuson was for the first five months stationed in London, where he was located in the same headquarters group as General Eisenhower and several other chiefs of staff.

The *Coatesville Herald* gave an account of some of Captain Fuson's experiences. He said that he remembered his first air raid in particular, because it was such an outstanding raid. He had started home when the siren blew, and because the searchlights and the fireworks were so pretty he and his companion decided to watch. The searchlights spotted a German plane, and as all London turned loose with anti-aircraft fire the pilot threw out three green flares which increased the already-brilliant lights, and the brilliance of the bursting anti-aircraft shells. About that time the flak from the shells began coming their way and Captain Fuson and his companion hit the ground, landing in a mudpuddle. They then and there decided that it was dangerous, and that they should get out of there. However, the German plane got away, but about eighteen planes were shot down that night, and Captain Fuson reports seeing one of them fall in flames. Captain Fuson says that during the raids you can get under a penny.

Since last June, Captain Fuson has been with a general hospital, where he has been in charge of the nose and throat department. The hospital cares for twelve to fifteen hundred patients continuously, and serves a number of airfields, caring for patients from heavy bomber group raids as they return to their bases.

Captain Lee J. Maris, of Attica, is stationed aboard a huge hospital ship which has been operating off the shores of Okinawa.

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We glean from a letter written by Lieutenant Wallace D. Buchanan, of Bremen, that he is well pleased with his assignment at Portsmouth, Virginia. "I am just getting settled in a new duty at the Portsmouth Naval Hospital; came down here from Philadelphia early last week. Had a marvelously pleasant tour at Philadelphia, and gained some very excellent instruction. Here I am attached to the regular staff as assistant to the radiologist. I will be doing that exclusively, and that is just what I prefer.

"This is a fine institution, but the representation from Indiana is a little scarce. I have found one man who graduated from Indiana University about 1929, but who had been living in Columbus, Ohio, since graduation—one Commander Judson D. Wilson."

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We take the liberty of quoting part of a letter written by Captain Floyd T. Romberger, of Lafayette, which was published in the St. Joseph County Medical Society *Bulletin:*

"I have begun my fifth year of continuous active duty with the Army. It hardly seems possible that I left South Bend so very long ago. I had no idea at that time that I still would be in the service in 1945, and I fear that it might be considerably longer, too. My job, which I am not able to discuss in much detail, requires that I travel a great deal from place to place. For the past six weeks I believe that there were only two or three times when I spent more than two nights in the same place. I even have my own office, which I put into operation several months ago.

"For a while I was living just about a mile from Fred Perry. I used to see him about once or twice a week. I also had the pleasure of meeting Wendell Spalding several times. However, I have not seen him since he returned from his leave some time back. Several weeks ago I bumped into Captain Pancost, from Elkhart. I am not certain just where he is now, as he was just reporting into his headquarters when I saw him.

"I have no idea what I am going to do after this is all over. I have practiced practically no medicine since I have been in the Army, much less any O.B. or Gyn. I fear that it is going to take me quite a while to get back into the swing of things. I have been thinking that perhaps I should go back and take about a year's residency or refresher course, because by the time I get out I fear I will have been away from my field nearly seven or eight years. What I would like to do would be to get transferred to a fixed hospital in the states following my return, just for a change. I fear that I shall not be afforded that opportunity, however."

(Yes, our boys are out there pitching, giving their all that we may retain our freedom.)

# News Notes

Dr. Carl Huckleberry has opened an office in Danville for the practice of medicine.

Dr. W. C. Landis, of Claypool, has accepted an appointment as physician at the Fort Wayne State School for Feeble-Minded Youth.

Dr. A. J. Kelsey, of Monterey, who has practiced in Pulaski County for almost fifty years, has closed his office and moved to Phoenix, Arizona.

Dr. H. P. Parker, formerly of Urbana, has opened an office at North Manchester for the practice of medicine.

Dr. Adrian R. Oleck, who is a staff member of the DuPont Medical Department at the Indiana Ordnance Works, in Charlestown, has opened an office in New Albany for the practice of his profession.

After serving for four years in the Army Medical Corps, Dr. Roy Lee Smith has returned to private practice in Indianapolis. For the last three years he was Chief of the Urology Section, Surgery Service, at the Fitzsimons General Hospital, at Denver, Colorado. Doctor Smith was a lieutenant colonel.

Purdue University officials have announced the appointment of Dr. Hedwig S. Kuhn, of Hammond, as a medical consultant to Purdue University's Industrial Vision Institute.

Dr. Kuhn and Dr. Albert C. Snell of Rochester, New York, who also has been named an institute consultant, will confer with leaders at Purdue about a developing industrial vision project for which much of the original research was carried on in Calumet area industries.

At the formal dedication of a new diagnostic treatment building, a seventy-five thousand dollar addition to Clearview Sanitarium, at Evansville, on June tenth, the speakers were Dr. C. C. Herzer, president of the Vanderburgh County Medical Society, and the Honorable Charles M. LaFollette. This new building increased the bed capacity from sixteen to thirty-two, and makes it possible to separate disturbed patients from convalescents.

Under the direction of Dr. Dillon D. Geiger, of Bloomington, the Indiana American Legion is forming an advisory staff of physicians to aid returning veterans of World War II. Each Legion Post has been asked to appoint a physician to act on the medical staff under the chairmanship of Doctor Geiger, who served as a major in the present World War with the Army Air Force Medical Corps.

Dr. John Swanson has closed his office in Fort Wayne, and has moved to St. Petersburg, Florida.

Dr. George V. Cring, of Portland, has been elected to a three-year directorship in the Indiana Tuberculosis Association.

Dr. Claude S. Black and Dr. L. W. Smith, both of Warren, attended a reunion dinner held in Indianapolis the last of April by the 1905 graduates of the Indiana Medical College. Twenty-four graduates attended the dinner.

The Seymour Clinic, Incorporated, has completed its dissolution, and the three doctors who had offices there have moved to other locations. Dr. Louis H. Osterman and Dr. H. P. Graessle have opened offices on West Second Street, and Dr. Charles E. Gillespie has his office on North Chestnut Street.

At the initial meeting of the Board of Health and Hospitals at the Indianapolis City Hospital on May first, Dr. Herman G. Morgan was named as secretary and director of public health. Dr. Charles W. Myers was appointed director of hospitals; Dr. Kenneth Kohlstaedt was named medical director of the Indianapolis City Hospital, with Dr. James D. Peirce as assistant director; and Dr. Gerald F. Kempf was appointed superintendent of Preventive Medicine. Other physicians appointed as members by Major Tyndall are Dr. Leonard A. Ensminger and Dr. Sumner A. Furniss.

## INDIANA UNIVERSITY NEWS NOTES

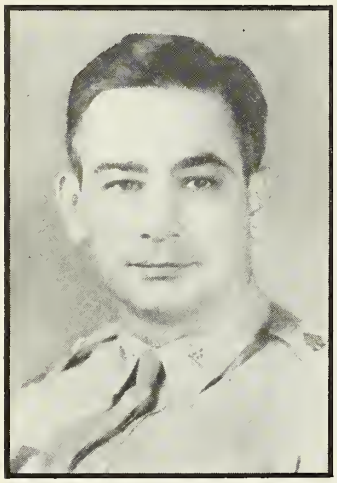
Twelve graduates from the medical schools of seven universities will begin serving their internship at the Indiana University Medical Center on July first, under appointments announced by Dean W. D. Gatch of the University's School of Medicine.

The Indiana University School of Medicine will graduate its next call in August, and members of that class appointed to Medical Center internship will begin their service in September. The new appointees and the medical schools from which they graduated are as follows: John F. Alden, University of Minnesota; John J. Benton, Johns Hopkins University; Jack L. Colglazier, University of Nebraska; Ernest H. Winterhoff, Ohio State University; Keith B. Witte, University of Wisconsin; Earl H. Clark, James D. Colt, and Stephen B. Phillips, University of Kansas; and Thomas G. Coleman, Howard E. LeBus, Donald D. Mitchell, and Thomas H. Obenchain, Jr., University of Texas.

# Deaths

## DIED IN MILITARY SERVICE

**Captain Robert B. Miller, M.C.,** of the United States Army, died on April thirtieth at the Percy Jones General and Convalescent Hospital, at Battle Creek, Michigan, from injuries received in the European theatre of operations.



*Captain Robert B. Miller*

Captain Miller entered the Officers Reserve Corps in 1935 and was called to active duty on December 10, 1940. Before going overseas in December, 1943, he served at Fort Benning, Georgia, and Camp Gordon, Georgia. Captain Miller remained with the Fourth Medical Battalion of the Fourth Infantry Division throughout the length of his foreign service. On D-Day he went ashore at Normandy, and was with the First Army through France and Belgium, and entered Germany with them. He was evacuated as a medical casualty from Hurtgen Forest, and was returned to the United States on December 25, 1944.

Captain Miller had received the American Defense Medal, the European theatre service ribbon with three Bronze Stars indicating three major battles, the Unit Citation, the Bronze Star Medal, and the Purple Heart.

Captain Miller was thirty-five years of age. He was a graduate of the Indiana University School of Medicine in 1934, and began the practice of medicine and surgery in Argos in 1935. He was a member of the Marshall County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**Lieutenant William Vincent Eckhart, M.C.,** of Marion, died instantly on May seventeenth when his automobile struck the rear of a heavily-laden trailer truck en route to Marion. He had been in the United States Army and had returned to Marion only a few days previous, having been placed on inactive duty.

*Lieutenant William V. Eckhart*

Doctor Eckhart was born in Marion, and was twenty-nine years of age. He received his Doctor of Medicine degree from the Jefferson Medical College of Philadelphia, in 1941, and had practiced in Marion for a short time with his father, the late Dr. G. G. Eckhart, who died on February 26, 1945, before entering service.

On September 14, 1942, he entered military service, and was first stationed at Camp White, Oregon. Later he served overseas in India and China. After returning to the United States in February, 1944, he was stationed at the Tilton General Hospital, Fort Dix, New Jersey, until the time of his retirement on April 17, 1945.

Doctor Eckhart was a member of the Grant County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**Seth Douglas Beavers, M.D.,** of Decatur, died at his home on May eleventh after an illness of six weeks' duration. He was eighty-five years of age. A graduate of Rush Medical College in 1886, Doctor Beavers had practiced in Decatur for more than fifty years. He was a member of the Adams County Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

**Edmund K. Ayling, M.D.,** of South Bend, died on April twenty-fifth after an illness of a few days. He was seventy-four years of age. Doctor Ayling was a graduate of the Northwestern University Medical School with the class of 1903, and had practiced in South Bend for twenty years. He was a member of the St. Joseph County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

**Charles Eugene Ferguson, M.D.**, of Indianapolis, died on May eighteenth after an illness of five months. He was eighty-eight years of age. He graduated from the Medical College of Indiana in 1892. Shortly thereafter he served for one year as the superintendent of the Indianapolis City Hospital, later resigning to become secretary of the Indianapolis Board of Health. Credit can be given to him for the city's modern system of water filtration, since it was largely through his efforts that it was installed. He was also influential in obtaining passage of the city's first plumbing and milk inspection ordinance.

*Charles E. Ferguson, M.D.*

Doctor Ferguson taught obstetrics for thirty years at the Indiana University School of Medicine, but failing eyesight forced him to retire twenty-three years ago. He has held the title of professor emeritus longer than any other man.

Doctor Ferguson was a Fellow of the American College of Surgeons, a member and past president of the Indianapolis (Marion County) Medical Society, and a member of the Indiana State Medical Association, and the American Medical Association.

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**Frank A. May, M.D.**, of Palmyra, died on May second at sixty-two years of age. A graduate of the University of Louisville School of Medicine, in 1909, Doctor May had practiced in Palmyra since 1926. He was a member of the Harrison County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**Oliver M. Morris, M.D.**, of Sheridan, died at the age of seventy-six, on May fourteenth. He graduated from the Indiana University School of Medicine in 1908. He had retired from practice.

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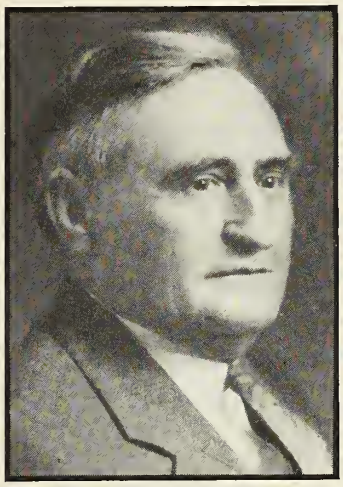
**John A. M. Aspy, M.D.**, of Indianapolis, died on June twelfth at the age of fifty-three. He was a graduate of the Indiana University School of Medicine in 1917, and had practiced orthopedic surgery in Indianapolis since 1919. In the first World War he served overseas; and in World War II he served as medical examiner for Selective Service Board No. 10. He was a member of the Indianapolis (Marion County) Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

**Ira E. Perry, M.D.**, of North Manchester, died June eighteenth at the age of seventy-two. Death was caused by a heart attack. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1905, and had practiced many years at North Manchester. He was especially interested in pediatrics.



*Ira E. Perry, M.D.*

Doctor Perry had served in various capacities in connection with the Indiana State Medical Association. He was a member of the Committee on Credentials in 1930 and 1931, a delegate in 1936, chairman of the Study Committee to Aid Needy Physicians in 1941 and 1942, and a member of the Committee on Industrial Health in 1944. He had also served as councilor for thirteen years, the last term being from 1935 to 1944. In his own community he had served as health officer for Wabash County for a period of fourteen years.

Doctor Perry was a member of the Wabash County Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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**Milton T. Jay, M.D.**, of Portland, died on May twenty-sixth at the age of seventy-seven. Doctor Jay graduated from the Medical College of Ohio, in Cincinnati, in 1890, and had practiced in Portland for more than half a century.

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**John B. Fattic, M.D.**, of Anderson, died May eleventh at the age of eighty-three. Prior to his retirement he had practiced in Anderson for more than forty years, after graduating from the Medical College of Ohio, in Cincinnati, in 1884. Doctor Fattic organized Medical Unit 1, in the first World War, and served with the rank of major as head of that unit in England and France during the war. He was a member of the Madison County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**Zed Thomas Hawkins, M.D.** of South Pasadena, California, died April twenty-sixth, at the age of seventy-eight. Doctor Hawkins was a graduate of the Eclectic Medical College, in Cincinnati, in 1893, and had practiced at Swayzee and Fairmount for fifty-one years before moving to California eight months ago. He was a member of the Grant County Medical Society, the Indiana State Medical Association, and the American Medical Association.

# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION

### EXECUTIVE COMMITTEE

March 18, 1945.

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; J. T. Oliphant, M.D.; N. K. Forster, M.D.; J. E. Ferrell, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney, and T. A. Hendricks, executive secretary.

Guests: John D. VanNuys, M.D.; Norman M. Beatty, M.D., and W. U. Kennedy, M.D.

Statements of receipts and expenditures for January and February for the association committees, and for February for THE JOURNAL were approved.

The Budget Committee will meet following the meeting of the Executive Committee.

#### Membership Report

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|---|---|
| Number of members March 17, 1945 | 2,603 |
| Number of members March 31, 1944 | 2,920 |
| Loss over last year | 317 |
| Number of members Dec. 31, 1944 | 3,399 |

Report made that no dues had as yet been received for 1945 from Adams, Bartholomew, Grant and Warrick counties. Suggestion made that the report in regard to these counties and other counties from which at least 50 per cent of the dues had not yet been received be turned over to the district councilors, with a request that the councilors contact the secretaries and see if the dues can be sent in as soon as possible.

#### Treasurer's Office

The committee approved the procurement of an all-inclusive bond on the association officers and the headquarters and Journal office personnel. This bond will cost about fifteen dollars more per year, but it will give the association more protection than that obtained under the provisions of the former bond.

The committee authorized an increase of five dollars a week in the salary of each regular full-time employee in the headquarters and Journal offices, exclusive of the executive secretary. This action was taken upon the motion of Dr. Forster, seconded by Dr. McCaskey.

It was reported to the committee that the loan of $2,000 from the Medical Defense Fund to the General Fund had been repaid. The committee approved the continuation of the loan of $3,000 from the Medical Defense Fund to the Journal Fund for another year.

Request made by the editor of THE JOURNAL that one dollar of the five-dollar war assessment be allocated specifically to THE JOURNAL, discussed by the committee. The committee felt that it had no right under the Constitution and By-Laws to allocate any part of this money specifically to THE JOURNAL, but the committee recommended to the Budget Committee that necessary funds be made available for the publication of THE JOURNAL.

#### Headquarters Office

The Executive Committee approved the payment of the executive secretary's salary upon a half-time basis; that is, the executive secretary is to receive one-half the compensation from the state association which he received in 1944. This arrangement is made due to the fact that he is spending half of his time as secretary of the Council on Medical Service and Public Relations of the American Medical Association.

#### 1945 Annual Session, French Lick, Tuesday, Wednesday, and Thursday, October 2, 3 and 4, 1945

*Chance for holding meeting.* The committee felt that changes in arrangements for holding the meeting should not be considered for the next sixty days.

Letter received from the chairman of the Section on Ophthalmology and Otolaryngology brought to the attention of the committee. The Council has recommended that section meetings be dispensed with, but that the sections be represented on the general meeting program.

#### Legislative, Legal and Social Security Matters

*National*

Current information suggests the probability that the Wagner Bill will be introduced soon.

Fourth Interim report of the Pepper Committee, together with special summary of the Pepper report, brought to the attention of the committee.

Hill-Burton Bill, approved by the Board of Trustees of the American Medical Association in principle, and sponsored by the American Hospital Association, discussed by the committee. This bill provides for an expenditure of $105,000,000 for hospitals. The recent Indiana State Legislature passed a bill which provides that federal funds shall be accepted in Indiana for building or enlarging hospital facilities only after a survey has been made in regard to these facilities by the State Board of Health.

The Ellender Bill, *S. 637*, including provisions for the deferment of adequate numbers of premedical students and medical students to supplement civilian sources of students, which has been approved by the American Medical Association, brought to the attention of the committee.

Letters from Congressman Raymond S. Springer, a member of the Judiciary Committee of the House of Representatives, to which the Tolan Bill has been referred, brought to the attention of the committee. The Tolan Bill carries the provision that chiropractors may treat federal employees under the Federal Compensation Act. The committee expressed its deep gratitude to Representative Springer for his interest in the bill and his understanding of the viewpoint of the medical profession in safeguarding the public health.

*Local*

Dr. Norman Beatty, co-chairman of the Legislative Committee, discussed the recent session of the legislature with the committee. The committee recommended that Dr. Forster, president of the association, write a letter of appreciation to Governor Gates.

Complaints against the osteopathic bill: Several letters voicing complaints from individual physicians or from county medical societies in regard to the osteopathic bill were brought to the attention of the committee. The entire story of the osteopathic bill was carried in the final report of the Legislative Committee, which appeared in the April issue of THE JOURNAL. In this respect, Dr. Forster presented a letter from Dr. Hugh A. Kuhn, of the Lake County Medical Society.

The committee suggested that Dr. Forster write the leaders of both the A. F. of L. and C. I. O., thanking them for their support and cooperation in regard to all matters having to do with scientific medicine at the recent session of the legislature.

The question in regard to the right of osteopaths to practice in hospitals was brought to the attention of the committee. Albert Stump, attorney for the association, was instructed to prepare a statement, pointing out that nothing in the recently-passed osteopathic law

in any way changes the situation concerning the right of osteopaths to practice in hospitals.

**Prepayment Medical Plans**

Dr. W. U. Kennedy, chairman of the Committee on Prepayment of Medical and Surgical Care, discussed the program that will be followed by his committee in preparation and recommendation of a plan for prepayment medical care to be placed before the House of Delegates of the state medical association. Dr. Kennedy explained that he was going to call a meeting of his committee when he could get the proper person from Washington to address the committee in regard to the political necessity of having his committee take such action. He stated that the profession itself must be educated to a point where it sees the necessity of such a plan, and will back such a plan.

Report made that labor is getting interested in the progress that the state association is making concerning the establishment of a medical care program that would correlate with the hospital insurance program.

**Organization Matters**

Report made that Rollen Waterson is resigning from the Lake County Medical Society to take a position with the Alameda, California, County Medical Society. His place is being filled by Mr. Rollis Weesner.

Announcement made by Dr. Forster that Dr. Murray Hadley had been appointed to represent the state association on the Indiana Traffic Safety Council.

**War and Postwar Medicine**

*County-by-county survey by Bureau of Information, A.M.A.* Dr. John VanNuys, chairman of the Committee on Postwar Medical Service of the state medical association, discussed the duties and the work of his committee with the Executive Committee. He will draw up a program of procedure to be presented to his committee at a future meeting. Subsequent to the meeting, Dr. Forster assigned the duty of completing the survey that is being conducted by the Bureau of Information of the American Medical Association to Dr. VanNuys' committee. The Bureau of Information is making this survey in an attempt to "provide a means of helping returned medical officers with their problems of licensure, education and practice."

Question in regard to state association membership for men in the regular army discussed by the committee. Following the last war, men in the regular army who desired to maintain their membership in the Indiana State Medical Association did so through the regular channels, that is, through their local county medical societies, and they paid the same state dues as any other member.

*Rehabilitation program.* Dr. Beatty explained the importance of the rehabilitation program that will be carried out through the State Department of Public Instruction. Dr. Beatty will keep in touch with this activity.

Authorization and accrediting of schools under the GI Bill of Rights discussed by Dr. Beatty and the committee. Dr. Ferrell made the motion that the president be authorized to appoint a Committee on Rehabilitation Services, whose duty it will be to act in coordination with the State Department of Public Instruction in regard to the rehabilitation program and the postwar education program of returned veterans. Subsequent to the meeting the following committee was appointed by Dr. Forster: Chairman, John Hewitt, Indianapolis; Bert C. Ellis, Indianapolis; Ray Elledge, Hammond; Myron Harding, Indianapolis; Robert B. Acker, South Bend; Vernon Hahn, Indianapolis; Keith T. Meyer, Evansville; Frank M. Gastineau, Indianapolis; N. H. Prentiss, Fort Wayne; James O. Ritchey, Indianapolis; James F. Balch, Indianapolis; W. D. Inlow, Shelbyville; Harold M. Trusler, Indianapolis.

**Socialized Medicine**

Debate upon socialized medicine at Purdue University, February 27, with Joseph E. Baldwin, who is head of the social service group in Lake County, taking the affirmative, and Albert Stump taking the negative, brought to the attention of the committee.

**Medical Economics**

Dr. John VanNuys made a report upon the contemplated organization of a Council of State Organizations that is being formed by the Indiana State Conference on Social Work. The committee suggested that Dr. VanNuys keep in touch with this group and act as representative of the state medical association with this group.

The ruling of the Federal Communications Commission in regard to diathermy machines, and the letters of protest from Dr. N. H. Prentiss, brought to the attention of the committee. Report was made that the Council on Physical Medicine of the American Medical Association had been in contact with the Federal Communications Commission and "the situation was well in hand."

**Future Meetings**

The date for the House of Delegates meeting of the American Medical Association has not yet been set.

**Public Relations, A.M.A.**

Copies of the News Letter of the Council on Medical Service and Public Relations of the A.M.A. brought to the attention of the members of the Executive Committee.

**State Board of Health**

Complaints in regard to the tuberculosis survey which was authorized by the Council of the state medical association in those counties approving the survey brought to the attention of the committee. The committee feels that there are some basic matters in these complaints that should be taken into consideration.

**The Journal**

Journal budget for 1945 referred to the Budget Committee.

*Rate for professional cards in Physicians' Directory for out-of-state physicians.* Out-of-state physicians who are members in good standing of other states, upon receiving approval of the proper officials in the state society in which they are a member, may have professional cards in the Physicians' Directory in THE JOURNAL of the Indiana State Medical Association. The rate for out-of-state physicians for these cards will be five dollars. This was approved upon the motion of Dr. Forster, seconded by Dr. Ferrell.

*Schieffelin and Company April advertising.* Dr. Forster made the motion, seconded by Dr. Ferrell, that the names of physicians in practice should be eliminated from this advertising.

*Hospital and sanatarium advertisements.* This question is to be discussed with Mr. Sandberg, of the Cooperative Medical Advertising Bureau.

*Subscription rates for non-members.* THE JOURNAL subscription rate for non-members is to be increased to five dollars per year.

There being no further business the meeting was adjourned.

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## EXECUTIVE COMMITTEE

### APRIL 22, 1945

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; N. K. Forster, M.D.; J. E. Ferrell, M.D.; F. T. Romberger, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney, and T. A. Hendricks, executive secretary.

Guests: W. H. Howard, M.D., chairman, Medical Economics Committee; John D. VanNuys, M.D., chairman, Committee on Postwar Medical Service; E. S. Jones, M.D., chairman, Committee on Industrial Health; N. E. Harold, M.D., Indianapolis, Paul Tindall, M.D., Shelbyville; John Webb, M.D., Indianapolis, and Ruth Kirk, Indianapolis, State Board of Medical Registration and Examination.

The statements of receipts and expenditures for March for the association committees and THE JOURNAL were approved.

**Membership Report**

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|---|---|
| Number of members April 22, 1945 | 2,732 |
| Number of members April 22, 1944 | 3,043 |
| Loss over last year | 311 |
| Number of members Dec. 31, 1944 | 3,400 |

The committee took the following action in regard to dues of veterans:

A veteran who has been discharged and who has already received his 1945 card shall not be charged dues for the remainder of 1945. However, he will be expected to pay in 1946. The fact that a discharged medical officer is taking postgraduate work does not relieve him of the obligation of paying dues to the state medical association.

**Headquarters' Office**

The following action was taken by the Executive Committee in regard to the employment of an assistant executive secretary: If arrangements are completed for a man to be employed on a half-time basis by the Indianapolis Medical Society, the committee approves his employment on a half-time basis by the state association. This motion was made by Dr. Forster and seconded by Dr. Romberger.

**1945 Annual Session, French Lick, Tuesday, Wednesday, and Thursday, October 2, 3, and 4, 1945**

Suggestion received from Dr. A. C. Yoder, member of the House of Delegates, that the meeting be transferred from French Lick to Indianapolis, if it is possible to hold only a delegates' meeting rather than an all-out convention with scientific program.

**Legislative, Legal and Social Security Matters**

**National**

Dr. N. K. Forster reported his acceptance of an invitation to attend a meeting of seventeen state society presidents, to be held by the Michigan State Medical Society, at Detroit, April 27 and 28. The committee approved acceptance of the invitation by Dr. Forster. It was understood that a great part of this meeting was to be devoted to the discussion of national legislation, with the possibility of some concerted movement for American Medicine to present a legislative program of its own to offset bills that might be introduced to further socialized medicine.

Report made that Senator Taft, of Ohio, was interested in presenting a bill based upon the platform principles of the American Medical Association, and that there was a Republican congressional committee especially studying proposals for health legislation.

Report made to the committee in regard to Governor Warren and the CIO bill for compulsory health insurance in California.

The committee was informed that Nathan Sinai, professor of Public Health Economics, University of Michigan, had appeared before a committee considering Governor Warren's compulsory health insurance measure as an expert witness in favor of this type of health insurance. Professor Sinai has appeared often in Indiana, discussing this matter under the guise of being a nonpartisan objective analyst in this field.

*The Wagner Bill.* It is understood that the Wagner health bill is being prepared and may be introduced soon.

*Hill-Burton Bill, S. 191.* This bill, which has been approved by the American Hospital Association, and in principle by the American Medical Association, providing $110,000,000 for the construction of hospitals, discussed by the committee. The committee felt that there should be some clarification and a definition in regard to what is meant by a "health center" in this bill.

According to word received, the *Ellender Bill, S. 637*, providing for certain deferments of premedical and medical students, has been slowed down. Letters have been sent to the Indiana senators by the state legislative committee and by local county legislative committees, asking that this bill receive a hearing, and favorable answers have been received from both the Indiana senators. Notice was also sent to the officers of the Indiana State Dental Association concerning the bill, and assurance was received from this source that they would contact the Indiana senators concerning this measure.

Bulletins from the Washington office of the American Medical Association distributed to members of the committee.

**Local**

Written report on state legislation, by Dr. Norman Beatty, co-chairman of the legislative committee of the state medical association, presented to committee.

*Osteopathic legislation.*

(a) Dr. Forster made a statement, voicing complaints he had received concerning the position of the Indiana State Medical Association in regard to this bill.

(b) The attorney of the association gave the opinion that the osteopathic legislation passed at the last session would have no effect on the rights of osteopaths to practice in hospitals.

(c) Correspondence from Marshall County in regard to the demands of an osteopath for admission to the hospital in that county brought to the attention of the committee.

Answers of Governor Gates and various groups, to letters of appreciation which were sent out by Dr. Forster, reviewed by committee. In these letters Dr. Forster had expressed the appreciation of the state medical association for the backing and help received by Governor Gates and leaders of various organizations in regard to medical legislation.

**Prepayment Medical Plans**

Announcement made that the Committee on Prepayment of Medical and Surgical Care would hold a meeting on April 29, at Indianapolis, upon the call of the chairman, Dr. W. U. Kennedy. Dean A. Clark, M.D., medical survey officer of the United States Public Health Service, is to be present and will outline the situation in Washington in regard to prepayment medical plans.

Report made that the Farm Bureau is now selling a health insurance policy. According to information received from the president of the LaPorte County Medical Society, the Bureau started to sell this policy some three years ago in Elkhart County, and they are now selling the policy in fifty-two counties of the state. Eleven hundred policies are now in force in LaPorte County; $1.20 per month covers a single person; $2.40 a month covers a man and wife, and $3.40 a month covers an entire family.

**Organization Matters**

Dr. N. K. Forster, president, gave an outline of activities to the chairmen of the following committees who were present:

Committee on Industrial Health—E. S. Jones, chairman.

Committee on Medical Economics — W. H. Howard, chairman.

Committee on Postwar Medical Service—J. D. VanNuys, chairman.

Committee on Physical Fitness—W. C. Moore, chairman, not present. (Copy of program forwarded to Dr. Moore.)

Legislative Committee—N. M. Beatty, co-chairman, not present. A statement from Dr. Beatty was presented to the committee.

OPA Medical Advisory Commitee—C. L. Rudesill, chairman, not present. Dr. Rudesill is to prepare an editorial giving the situation in regard to OPA as it applies to medicine in Indiana.

*Medical Relief Committee.* Letter received from Dr. Eugene Boggs, chairman, in regard to a meeting of his committee. The Executive Committee felt that it was up to the chairman to determine the need for a meeting.

*Objectives of proposed Council of State Organizations for Indiana.* Under the direction of the Indiana State Conference on Social Work, a Council of State Organizations has been organized. The objectives of this Council are presented in a letter received from Judge Wilfred Bradshaw. Dr. John VanNuys, who has acted as a representative from the Indiana State Medical Association with the group that is organizing the Council on State Organizations for Indiana, stated that he felt that he could approve the objectives as set forth by this organization. The secretary was instructed to forward the letter from Judge Bradshaw and the objectives to Dr. Eugene F. Boggs, chairman of the Medical Relief Committee, for study.

#### State Board of Medical Registration and Examination

The following members of the State Board of Medical Registration and Examination met with the committee: N. E. Harold, M.D., Indianapolis; Paul Tindall, M.D., Shelbyville; John Webb, M.D., Indianapolis, and Ruth Kirk, executive secretary, Indianapolis.

#### War and Postwar Medicine

The Bureau of Information of the American Medical Association, established to supply information concerning medical facilities throughout the nation for the returning medical officer, has asked each state society to make a county survey. Summary sheets in regard to this survey have been sent to the Indiana State Medical Association, and the headquarters' office of the state association, under the direction of Dr. John VanNuys and his committee on Postwar Planning, in turn has sent these sheets to each county medical society, and to date the committee has heard from forty-seven counties.

Recommendations have been made that an advisory committee be appointed to the office of Clement T. Malan, superintendent of Public Instruction. This advissory committee is to work particularly with the Department of Public Instruction concerning information in regard to accredited schools, under the GI Bill of Rights. This, of course, is a most important matter, as schools to be accredited for attendance of a veteran who receives funds for his education are passed upon, not by the federal government but by local educational agencies in each state. This committee is to be appointed in the near future.

#### Socialized Medicine

Committee was informed that a bill to socialize medicine was introduced in Michigan.

Report made that the California socialized medicine bills are still being held in committee.

Report also made that Nathan Sinai, professor of Public Health Economics, University of Michigan, had appeared before a committee of the California legislature as an expert witness and advocated the passage of Governor Warren's bill in California, which provides for compulsory health insurance.

#### Medical Economics

*Indiana State Conference on Social Work.* Dr. Eugene F. Boggs and Dr. John VanNuys appointed delegates from the state society to this group.

*Alcoholics Anonymous.* Word was received by the committee that an Alcoholics Anonymous institution had been established in Indianapolis. Upon the basis of facts at hand concerning the work of this organization, the committee felt that such an institution could be approved by the medical profession.

Right of physician to keep confidential case histories discussed by Albert Stump, attorney, before the committee. The committee is to discuss this further at the next meeting.

*National Medical Society, Hans Zimmerman, secretary.* Indiana physicians are being solicited for membership in this organization, according to a bulletin issued by the Council on Medical Service and Public Relations of the American Medical Association. From other sources it is learned that many of the leaders of this organization are not physicians, but are naturopaths and members of cult groups.

#### Future Meetings

A. M. A. House of Delegates' meeting probably will not be held until after August.

Woman's Auxiliary to the Indiana State Medical Association, April 26. Dr. Ferrell, president-elect, Dr. Beatty, co-chairman of the Legislative Committee, and the secretary of the state association have been asked to appear on the program.

#### State Board of Health

Letters received from M. A. Auerbach, executive secretary of the Indiana Tuberculosis Association, in regard to criticisms concerning the x-ray survey that is being conducted by the State Board of Health, with the sponsorship of the tuberculosis association, brought to the attention of the committee. Mr. Auerbach reports that at a recent meeting of the Indiana Chapter of the American College of Chest Physicians, the question as to whether the mass x-ray program should be postponed at this time was presented, and the chapter unanimously voted that the program be continued without interruption.

#### The Journal

*Advertising rates.* New JOURNAL advertising rates approved by the committee. This includes the new color rates.

The Executive Committee approved a schedule for rates for preferred space in THE JOURNAL, as presented by Miss Rokke, assistant editor of THE JOURNAL.

Restriction in regard to reprints discussed by the committee, and the committee hoped that THE JOURNAL printers will be able to supply these reprints as in the past without affecting the supply of paper stock for THE JOURNAL. Letters have been received from physicians complaining about the restriction on the supply of reprints.

The committee approved raising the rates for commercial announcements from $2.00 to $3.00 for fifty words or less, with a charge of $.50 per line for lines in addition to fifty words.

There being no further business the meeting was adjourned.

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## LOCAL SOCIETY REPORTS

**Grant County Medical Society** members were entertained by the Owens-Illinois Glass Company on May tenth, with a luncheon. A talk on occupational diseases in the glass industry was given by Dr. Louis Spolyar, of Indianapolis. Following the talk the guests were taken on a tour of the factory.

**Greene County Medical Society** members were guests of Dr. H. B. Turner and Dr. Frank A. Van Sandt, at Dr. Turner's home in Bloomfield, for a dinner meeting on May seventeenth. A business meeting followed the dinner. Eleven members were present.

**Tippecanoe County Medical Society** members held a meeting at the Lincoln Lodge, in Lafayette, on June twelfth. The guest speaker was Theodore K. Lawless, M.D., of Northwestern University, whose paper was entitled "Syphilis: Management and Sociological Aspects." The lecture was illustrated by the use of slides. Thirty-five members attended the meeting.

**Floyd County Medical Society** members met at the Frances Cafeteria, in New Albany, on June eighth. Dr. Augustus P. Hauss, of New Albany, spoke on "The New Wagner-Murray-Dingell Bill." Ten members were present.

**LaPorte County Medical Society** members held a meeting at the Dr. W. W. Ross' cottage, in LaPorte, on May seventeenth. The guest speaker was Dr. John L. Lindquist, of Chicago, whose subject was "Traumatic Conditions of Extremities." Twenty-two members attended this meeting.

**Marshall County Medical Society** members met on June sixth at Plymouth for a meeting at which Dr. Max Garber, of Rochester, New York, was the guest speaker. His subject was "Rheumatic Fever in Children." Twelve members were present.

**St. Joseph County Medical Society** members met on May twenty-third at the South Bend Country Club for their annual family night dinner. Following the dinner an entertaining program was presented, including a magician and community singing. Wives of doctors who are in service were guests.

## Councilor Meeting

### ELEVENTH COUNCILOR DISTRICT MEETING

The seventy-third semi-annual meeting of the Eleventh Councilor District of the Indiana State Medical Association was held at the Logansport City Building on May sixteenth for a scientific program and business meeting with election of officers. Colonel W. W. Holmes, of Logansport, spoke to the assembly on his war experiences the past few years, and Dr. F. B. Mitman, retiring president, spoke on the future of the district. Three technical discussions were presented by Dr. John R. Brayton and Dr. Kenneth L. Craft, both of Indianapolis, and Dr. Lall G. Montgomery, of Muncie. Approximately sixty members attended the meeting.

### RADIO CALENDAR

"YOUR HEALTH IN WARTIME"

Hear these broadcasts each week:

Indiana State Medical Association — Doctor Goodhealth—Monday, 2:00 P.M., WFBM, Indianapolis.

Vigo County Medical Society — Thursday, 12:15 P.M., WBOW, Terre Haute.

St. Joseph County Medical Society—Friday, 1:45 P.M., WSBT, South Bend.

Howard County Medical Society—Friday, 6:30 P.M., WKMO, Kokomo.

Vanderburgh County Medical Society—Saturday, 10:00 A.M., WGBF, Evansville.

# Woman's Auxiliary

to the

## INDIANA STATE MEDICAL ASSOCIATION

### STATE OFFICERS

President: Mrs. Frank M. Gastineau, Indianapolis.
President-elect: Mrs. Samuel J. Petronella, East Chicago.
Councilor: Mrs. James W. Baxter, New Albany.
First vice-president: Mrs. C. E. Munk, Kendallville.
Second vice-president: Mrs. K. T. Knode, South Bend.
Third vice-president: Mrs. Wayne Elston, Lapel.
Fourth vice-president: Mrs. R. G. Burman, Jeffersonville.
Treasurer: Mrs. A. W. Ratcliffe, Evansville.
Recording secretary: Mrs. Leon L. Blum, Terre Haute.
Corresponding secretary: Mrs. C. L. Bock, Indianapolis.
Parliamentarian: Mrs. Charles F. Voyles, Indianapolis.
Historian: Mrs. Harry L. Foreman, Indianapolis.

### CHAIRMEN OF STANDING COMMITTEES

Archives: Mrs. W. R. Morrison, Kokomo.
Bulletin: Mrs. Ernest O. Nay, Terre Haute.
War service: Mrs. Karl M. Koons, Indianapolis.
Finance: Mrs. Charles Wise, Camden.
Hygeia: Mrs. Otto H. Bakemeier, Indianapolis.
Legislation: Mrs. F. B. Wishard, Pendleton.
Press and Publicity: Mrs. Arthur B. Richter, Indianapolis.
Mrs. Emmett B. Lamb, Indianapolis.
Mrs. J. W. Ricketts, Indianapolis.
Program: Mrs. E. N. Mendenhall, Fort Wayne.
Public relations: Mrs. J. W. Mather, East Gary.
Physical fitness: Mrs. N. H. Prentiss, Fort Wayne.

### COUNTY PRESIDENTS

Allen—Mrs. N. H. Prentiss, Fort Wayne.
Carroll—Mrs. C. L. Wise, Camden.
Cass—Mrs. Daniel E. Lybrook, Galveston.
Clark—Mrs. C. F. C. Hancock, Jeffersonville.
Delaware-Blackford—Mrs. O. W. Owens, Muncie.
Elkhart—Mrs. Floyd M. Freeman, Goshen.
Floyd—Mrs. A. M. Baker, New Albany.
Hancock—Mrs. J. E. Ferrell, Fortville.
Howard—Mrs. G. N. Druley, Kokomo.
Lake—Mrs. J. W. Mather, East Gary.
LaPorte—Mrs. R. B. Engstrom, Michigan City.
Madison—Mrs. Guy E. Ross, Anderson.
Marion—Mrs. H. S. Leonard, Indianapolis.
Marshall—Mrs. Maurice O. Klinger, Plymouth.
Northeastern Indiana Academy of Medicine—Mrs. C. E. Munk, Kendallville.
Porter—Mrs. A. J. Van Winkle, Valparaiso.
St. Joseph—Mrs. M. J. Thornton, South Bend.
Tippecanoe—Mrs. John T. Morrison, Lafayette.
Sullivan—F. M. Dukes, Dugger.
Vanderburgh—Mrs. Mell B. Welborn, Evansville.
Vigo—Mrs. Claude A. Curry, Terre Haute.

## REPORTS OF OFFICERS AND COMMITTEES*

### PRESIDENT'S REPORT

Mrs. Frank M. Gastineau

As president of the Woman's Auxiliary to the Indiana State Medical Association, it is a pleasure and an honor to submit the following report:

I wish to take this occasion to extend to the officers, the chairmen of standing committees, the county presi-

* Presented before the House of Delegates Meeting of the Woman's Auxiliary to the Indiana State Medical Association, at Indianapolis, on April 25, 1945.

dents, the delegates, and each individual member of the auxiliary my heartfelt thanks for the wonderful cooperations I have had during the last six months.

We are meeting today to hear the reports, to get inspiration to take back to the county auxiliaries, and to plan for our future meetings. That so many of you have put forth the effort to come to this meeting gives ample testimony of your interest and devotion to the auxiliary work. Our fall board meeting was held in November, at the Columbia Club, and we had a record attendance of thirty-one members. Reports were given and plans outlined by the chairmen for the year's work. We have 937 members in the state auxiliary, an increase of 167. This is the largest membership in the history of the auxiliary. Our *Hygeia* and *Bulletin* subscriptions have surpassed all our former endeavors. One new county has just been organized, but not in time to count in this year's membership. If the auxiliary can continue to expand during these critical times, I am sure that we will have a phenomenal growth when our doctors who are at war return.

I have attended only five county auxiliary meetings, but since I have twelve more months in office I will have plenty of time to visit other auxiliaries, if you wish.

This meeting is, as you designated last year, an experiment; it will not follow exactly the pattern of the fall meetings of the past. Since we are skipping the election this time, and the memorial service seemed to be a mark of respect that should be presented to the whole body at the fall meeting, I consulted some of the executive board members, and we decided to invite some guest speakers. They will talk to you on subjects pertaining to our auxiliary work.

I hope you will get some ideas from our speakers, your chairmen, or the other county presidents reports today, so that you may add at least one thing more to your program next year, and make your organization of better service to your doctors and your community.

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### WAR SERVICE

Mrs. Karl M. Koons

Reports about War Service, members participating and hours spent, were received from nine auxiliaries. Four hundred and thirteen members gave a total of 156 days and 88,032 hours in many fields of war service. Two other auxiliaries reported eighty-six members doing war work, but gave no estimate of hours. Eleven auxiliaries sent no report.

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### ORGANIZATION

Mrs. F. M. Gastineau

Last February I went through the files in the offices of the Indiana State Medical Association and made a list of the names and addresses of the doctors in active practice in the counties that do not have an auxiliary. I sent to each of these doctors wives a letter composed by Mrs. A. H. Duemling, national chairman of the organization in this district. I sent almost seven hundred letters. As a result, we now have ninety-five members at large. I received many gratifying letters in response, evidencing an interest in the auxiliary.

A few counties seemed to have a large number of interested people, and I believe we can contact the medical society in these places and form additional auxiliaries. I assumed the work of the vice-presidents because I had access to the files at the medical association headquarters. I hope soon to be able to divide the lists of names of the people contacted, and the ones joining the auxiliary, in four parts and turn the work over to the vice-presidents for next year's organization. We have 937 members in the auxiliary, an increase of 166. Two hundred and sixty-six are members, 95 are members at large.

I wish to thank Mrs. Ratcliffe for the extra work that she has had to do in connection with obtaining members at large. We have one new auxiliary in process of organization. They have elected a temporary chairman, are drawing up their constitution, and have thirteen women signed up to become charter members.

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### HYGEIA

Mrs. Otto H. Bakemeier

In comparison with former years, as far back as we have records, the Woman's Auxiliary to the Indiana State Medical Association has made a better showing with *Hygeia* this year than ever before, with a 40 per cent increase over last year's subscriptions.

Five counties made their quotas, and three were mentioned in the national report as having gone over their quotas, having at least twenty-five subscription points. Many counties doubled and tripled their last year's record.

To the county *Hygeia* chairmen and members, the state *Hygeia* chairman wishes to express her appreciation and thanks for the wonderful cooperation you have given.

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### LEGISLATION

Mrs. Fred B. Wishard

At the beginning of the fiscal year our members were urged to become informed concerning all medical legislation—and especially so concerning the issues that were to arise in the Indiana state assembly. It was suggested that the auxiliary members read each issue of *The Journal of the American Medical Association,* and also THE JOURNAL of the Indiana State Medical Association, as well as all other articles in newspapers and periodicals.

Fifteen confidential bulletins were sent to each auxiliary unit.

As legislative chairman, I kept informed as to pending legislation, and stood ready to act by calling upon the auxiliary should support of any bill have been needed. It was reported by some auxiliary members that they did write to their representatives.

I feel that the Woman's Auxiliary to the Indiana State Medical Association does play a part, however small, in support of the policies of the parent organization.

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### ARCHIVES

Mrs. W. R. Morrison

Since October I have written twenty-two letters, and received eight responses. I have pasted all material received in a scrap book. I would suggest that you send in pictures wherever feasible. It is not necessary to duplicate articles when there is more than one paper. It might be well to limit the number and length of some, for the pages are overflowing in a few cases.

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### PRESS AND PUBLICITY

Mrs. Arthur B. Richter

Since October, fourteen counties have had reports in THE JOURNAL. Several counties have had reports in more than one issue. THE JOURNAL office has been kind in sending newspaper clippings pertaining to the auxiliary. This committee has appreciated the thoughtfulness and cooperation of THE JOURNAL staff, particularly Miss Nella Rokke. Business items pertaining to the organization have been published. We have had approximately 109 inches of publicity given us by THE JOURNAL. Due to the paper shortage experienced by the magazine, our material has been set in small type this year. We have had to discontinue using personal items for the same reason.

Our annual county reports will be compiled and published this summer, probably in the July issue. At this time it seems doubtful that we will be able to secure reprints.

Newspaper publicity for the House of Delegates meeting was arranged for, and in the event of another meeting in the fall we will cover that.

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### BULLETIN

Mrs. Ernest O. Nay

The *Bulletin* is your auxiliary publication. It contains many excellent addresses and information concerning the plans of the national program, and should be read by every member.

Each county auxiliary has been solicited several times for subscriptions to the *Bulletin*. This year the total number of subscriptions from Indiana is sixty-four, which is nine subscriptions over the total of last year.

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### PUBLIC RELATIONS

Mrs. J. W. Mather

I have received a generous number of replies from the different counties in regard to their activities during the past six months.

From these reports we find that doctors' wives have been leaders in community activities. Many have given hours and days to the promotion of War Bond sales; to hospital service, as nurses aides, gray ladies, and to blood banks. They have been faithful and persevering in Red Cross work, varying from sewing, knitting, and preparing surgical dressing to home visitation for the servicemen's families who have problems and needs. Many have been active in the U.S.O., O.C.D., ration boards, and in P.T.A. groups.

Indiana doctors' wives have rallied to the call for care and donations for our service hospitals. Particular commendation goes to Marion County in this respect. In my own county—Lake, under the able supervision of Mrs. H. M. Baitinger, the doctors' wives have taken an active interest in the Wakeman General Hospital, at Camp Atterbury. They have not only donated goods themselves, but have been active in getting lay groups interested in the hospital and the needs of the wounded. I visited the Porter County Auxiliary in March and found a congenial group actively interested in promoting health education in the schools, and in the Parent-Teachers Association. They also had spent considerable time on legislative study.

While the world is still embroiled in war, we feel that we, as a group, should do all we can to ameliorate the suffering and hasten the day to peace. In looking toward that day of peace, we feel that the first aims of the National Constitution of the Auxiliary to the American Medical Association, "To extend the aims of the medical profession to all organizations which look to the advancement of health education," should take an increasing part of our time and effort. Three hundred pamphlets, "Doctors Look Ahead," were distributed throughout the membership. Attention was called to radio and transcription programs on health and health education. Groups were encouraged to promote public meetings, giving the medical viewpoint in health problems.

We as a group need to acquaint ourselves first with the aims of the medical profession, to study and read medical journals, to attend auxiliary meetings, and keep informed as to the activities of the national auxiliary through study of the *Bulletin*. No officer can do efficient work otherwise.

The Public Relations chairman has urged the distribution and reading of *Hygeia*—this activity being expressly desired by the American Medical Association.

Finally, each member is urged to regard herself as an especially-chosen representative to help create a better understanding of her husband's work and the high ideals of his profession among her associates and the groups with which she is affiliated.

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### PROGRAM

Mrs. E. N. Mendenhall

An outline of possible topics for study and discussion in medical auxiliary meetings was compiled and submitted to our State Advisory Board and National Chairman of Programs for approval. It was approved and ready for distribution to all county presidents or their representatives at the annual meeting, in Indianapolis, last September. A copy was mailed during the following week to those who were not present to receive it.

The material included in the outline was classified as follows: Public Relations, Education, Legislation, and Social. So that the information on topics selected could be easily found, a bibliography of source material was compiled for most of the subjects.

March 30, 1945, a short, double post-card questionnaire was mailed to each of our twenty-one county presidents. Four short directions, indicating how the blanks were to be filled out, the time limit for return, the period to be covered by the report, and how to list Red Cross work were given.

Fifteen cards were returned by April 10—the time limit indicated.

Two cards were two days late.

To the remaining four, a second card was sent. Two more counties responded, leaving LaPorte and Madison counties not reporting.

It is frequently difficult to distinguish which subjects are Educational, which are Public Relations, and which are Legislation, as they may definitely overlap. The type must be left to the judgment of the reporter.

The questionnaires yielded the following interesting statistics:

Of the nineteen counties reporting, two do not have regular meetings. One of these held one legislative meeting, and one held one social meeting.

Nineteen counties reported thirty-three social meetings.

Nineteen counties reported nineteen legislative meetings.

Seventeen counties reported thirty-six educational meetings.

Seventeen counties reported sixteen public relations meetings.

Seven counties reported twenty war participation meetings.

Three counties reported sixteen combination meetings, that is a social hour at each meeting.

Last year social meetings were most popular. This year educational meetings are most popular—a marked increase since the statistics showed one county having all of its six meetings as social meetings. Public Relations show an increase over last year, and this year seven counties were reported engaged in war participation as units. This is the most healthful growth ever shown in comparison with past years' activities.

The last three items of the questionnaire could have been interpreted as personal. They were:

1. Do the program outlines help you?
2. Does the bibliography of source material help you?
3. Give suggestions for improvement. These were intended to be fact-finding, to confirm my belief that the program suggestions are never used or even looked at.

The results were as follows:

Two counties reported no outlines received.

Ten counties reported the outlines and bibliographies to be helpful.

Three counties reported that they do not help.

One county reported that it had no opportunity to use the outline—all of its meetings are social.

One county reported the outline helpful, but that the bibliography of source material was not beneficial.

One county reported the outline of topics as of no help, but that the bibliography was helpful. Since the source material pertained to the topics of the outline, that answer is unusual.

Of the nineteen counties reporting, three presidents replied to suggestions for improvement of the program outline. Two of these were made by very dear, personal friends and therefore unreliable. One is very modernistic and cute—"Keep Kits Komming."

## ANNUAL REPORTS FROM COUNTY AUXILIARIES

### ALLEN COUNTY

Mrs. N. H. Prentiss, President

NUMBER OF MEMBERS:

| | |
|---|---|
| Total membership | 103 |
| New members | 10 |
| Affiliate members | 5 |
| Lost | 2 |

(Forty-nine husbands are in the service at the present time. Twenty-six wives are with their husbands. They pay no dues, but are carried on the roster.)

MEETINGS:

| | |
|---|---|
| Total number of meetings | 8 |
| Social | 3 |
| Legislation | 1 |
| (Some at two other meetings) | |
| Educational | 4 |
| Average attendance | 45 |

LEGISLATION:

Letter of protest was sent to Senators Charles A. Phelps and Lucius B. Somers against passage of Bills Nos. 181 and 193. Resolutions of protest were drawn up and signed by thirty-five members.

Preceding the November election a list of candidates was printed and distributed to the offices of doctors and dentists. The candidates were avowed opponents of socialized medicine.

PUBLIC RELATIONS

We sponsored a joint meeting with the Allen County Medical Society. Captain W. A. Bassow, M.C., Flight Surgeon, Army Air Corps, spoke on "Malaria and Other Tropical Diseases."

*Christmas Seal Booth*

Three days—December 7, 8, and 9, 1944; 13 members gave 23 hours. Amount sold, $36.73.

*War Participation Activities*

Doctor's aides, U.S.O., S.M.C., military news concerning Allen County men and women in service—that is, doctors, dentists and nurses—published monthly in "Caduceus," the official bulletin of the Fort Wayne Medical Society.

Nurses aides, training of nurses aides, and War Chest soliciting.

Sixty-four Christmas gifts, donations of our members, delivered to Medical Corps men at Baer Field.

*Civilian Defense*

Ration Board work; nursing; nursing deputy county health officer; and two members full-time physicians and surgeons.

*Red Cross:*

1. Nurses' aides and staff assistants.
2. Administration.
3. Blood Bank: all graduate nurses furnished by the auxiliary since the establishment of the blood bank nearly two years ago; canteen workers; hostesses, and donors.
4. Production: Sewing and knitting.

Members of Liaison Committee drew up a health program. Its purpose is to encourage more normal behavior in juveniles and adults through building and maintaining a sound health level. One program was presented to 117 teen-agers, and a schedule for further programs is being arranged. Health film is being supplied by our auxiliary for use in the city parks this summer.

*Hygeia*

Ninety-five Subscriptions (3 over our quota).
Ten *Bulletin* subscriptions.

*Library*

Reading material was placed in the Fort Wayne Public Library. The subject, "Nutrition," has been a project for three years. Due to the rationing of food, it has been a difficult project to promote.

*Press and Publicity:*

Three hundred inches in two local papers; two flag heads; and six pictures.

### CARROLL COUNTY

Mrs. Charles L. Wise, President

Carroll County Medical Auxiliary, with a membership of four, has met once each month with the doctors for a dinner meeting, and discussion of problems in the county. One of our members has charge of all Red Cross work in the county, as she has had for the past twenty-five years. She gives four hours each day, five days a week, to the work of the Red Cross. Another member assists her husband in his office about six hours a day. A third member is a busy mother, a club and church worker. The fourth is a club president, does knitting for the Red Cross, and assists in organizing Red Cross classes of Home Nursing. One older member asked that I come to these meetings to keep us represented and alive for our inactive members who will return when this world conflict ends.

We report one subscription to the *Bulletin*, and three to *Hygeia*.

### CASS COUNTY

Mrs. Daniel E. Lybrook, President

The Cass County Auxiliary had eighteen members this past year, with an average attendance of nine members. We have held six meetings, four of which were in combination with the doctors' meetings. We have devoted eighteen hundred hours to war work of all types. The public relations contact has been as a group through the Public Welfare and Parent-Teachers' Associations. There were thirty-one subscriptions to *Hygeia*, and copies of this magazine were distributed to the U.S.O., Y.W.C.A., and the railroad stations.

### CLARK COUNTY

Mrs. C. F. C. Hancock, President

A card party was given to raise money. *Hygeia* subscriptions were given local high schools. Eleven *Hygeia* and three *Bulletin* subscriptions were sent in. Sewing for the Clark County Hospital and social meetings alternate. We furnished one room at the U.S.O. A tea was given for nurses' aides. We sent one member to assist each time with the T.B. clinic. Donations have been given to all drives for funds, such as Infantile Paralysis, Cancer, Tuberculosis, et cetera. Members assist in various war activities. Speakers were secured for some meetings.

### DELAWARE-BLACKFORD COUNTIES

Mrs. O. W. Owens, President

The war has taken so much of our time and thought that this county has not been very active this year. There were three meetings. One member is working on the Cancer Control campaign.

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### ELKHART COUNTY

Mrs. Floyd Freeman, President

This Auxiliary has a membership of twenty-five. To date there have been four meetings, three in Elkhart and one in Goshen. In May, after the election of officers, the group was entertained by the medical society at dinner and for a program. We find it difficult to arrange meetings because of gas shortage. To conserve, we endeavor to meet on the same evening as the medical society. Since they always have a dinner meeting, it follows that our society must have one, too. That in itself constitutes a problem, although we have had some delightful "carry in" suppers in the home of members. All members are faithful workers at Red Cross, although we cannot give the exact number of hours. Our subscriptions to *Hygeia* are 100 per cent. We donated ten dollars to each of the following: Red Cross, Society for Crippled Children, and Society for Cancer control.

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### FLOYD COUNTY

Mrs. A. M. Baker, President

The Floyd County Medical Auxiliary had the following meetings: In January there was a luncheon with a "Legislative" program. In February there was an afternoon meeting with a "Health Education" program. The auxiliary joined the Clark County Medical Auxiliary at luncheon in March. Another afternoon meeting was held in April, and the members were entertained with music. "Juvenile Delinquency" was the subject for the May afternoon meeting. In June there was a covered-dish luncheon, and the program was on "War Service and Rehabilitation." Each meeting was closed with the Collect of the Woman's Medical Auxiliary. There were thirteen *Hygeia* subscriptions and four to the *Bulletin*. We are all working in war service in some way or other. Because of this, there has been a small attendance at the meetings.

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### HANCOCK COUNTY

Mrs. J. E. Ferrell, President

There is a total membership of fifteen. In December there was a social meeting and election of officers. The County Medical Society entertained us in April. Doctor Ferrell discussed several topics that were of great interest to the doctors, as well as the women. We completed the evening with a general discussion by everyone. Under the project of getting the history of some physician in the county, it was voted to write up Dr. J. E. Ferrell, as he is the president-elect of the Indiana State Medical Association for 1946, and the first physician from this county and district to receive this honor in forty years. Under war work, there has been about one hundred hours spent at knitting. One member has spent ninety-six hours teaching Home Nursing. Forty-five hours were spent on bandages, and ten hours on Red Cross Funds. We sold eleven subscriptions to *Hygeia*, and one to the *Bulletin*.

### HOWARD COUNTY

Mrs. G. N. Druley, President

The Woman's Auxiliary to the Howard County Medical Society has a membership of twenty-three. Three members paid dues after March 1, 1945; therefore were delinquent, making a total of twenty-six paid memberships. Eight meetings were held during the year, with an average attendance of sixteen. Due to the transportation problem and the gasoline rationing, no outside speakers were obtained for the meetings. However, our state president was our guest speaker in May. The program and legislative chairmen kept us informed at each meeting concerning medical legislation, both national and state. During the last session of the state legislature detailed accounts of bills presented regarding the health and welfare of the people were studied. One meeting was given over to a discussion of the proposed prepaid health insurance plans under discussion by the state medical society. One of our members prepared a paper on "Musical Therapy," which was given before many civic and church groups. Three subscriptions to *Hygeia* and the same to the *Bulletin* were reported. Auxiliary members reported that *Hygeia* was on their husband's desks, but took no credit for placing them there.

Our members have given many hours to the Red Cross in all its phases, to the Blood Bank, OCD, and U.S.O. Four of our members are working full time in their husband's offices. One member is in the Department of Public Welfare.

Our programs have not been as outstanding as last year's. However, we have done all the work ourselves, and feel that we have a right to be proud of our efforts. We are carrying the torch for the wives whose husbands are in service, and pledging ourselves to the task of giving them a good society on their return.

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### LAKE COUNTY

Mrs. J. W. Mather, President

Lake County has a membership of seventy-seven, twelve of whom are carried as servicemen's wives. There were seventy *Hygeia* subscriptions, but only forty-one were credited by the national association. Twenty gift subscriptions were sent to Wakeman General Hospital, by the Hammond Branch. There were seven *Bulletin* subscriptions.

*War Service:*

I. For the Wakeman General Hospital, Camp Atterbury:
   a. Twenty subscriptions to *Hygeia*, by Hammond group.
   b. Several complete files of magazines, by Hammond group.
   c. Thirty books for the library, by the Gary group.
   d. Donations of home-made candy and cookies, by the Gary and Hammond groups.
   e. Ten bedside kits made and filled by the East Chicago Branch.
   f. Thirty boxes of Christmas greeting cards by Gary Branch.

II. East Chicago-Whiting Branch sent Christmas gifts of soap to forty-two nurses overseas.

III. Membership Participation:
   a. Mrs. H. M. Baitinger, of Gary, Red Cross chairman for Lake County, is in charge of gifts and services for the Wakeman General Hospital, at Camp Atterbury.
   b. Members have been active in Red Cross work.
      1. Knitting, surgical dressings, sewing, Bond sales, and ration boards.
      2. Volunteer Home Service, thirty hours per week.
      3. Motor Corps, Gray Lady, Instructor for Cadet Nurses, Instructor for Nurses Aid, and Advisory Council for Nurses Aid.

*(Continued on page xxix)*

*(Continued from page 252)*

All members are conscientious regarding waste-paper, tin, and waste-fat saving. Fifteen dollars was donated by the auxiliary to the Cancer Control project.

Our meetings have been given generous publicity in the county papers, and have been reported in the medical journals, county and state.

Educational meetings have been held, with the following programs: "Nutrition"; "How Lake County Copes with the Juvenile Problems of Today"; "The Work of the Coroner"; and "Medical Legislation."

*Public Relations:* A survey of the association of all members with other organizations, religious and secular, is planned in order to be able to reach a large number of people when it is necessary to present the medical view of legislative matters, such as the Wagner-Murray-Dingell Bill. It is felt that it is the responsibility of each doctor's wife to first keep herself informed, and secondly, to help to keep her associates informed along ethical medical thinking. The president of the auxiliary to the Lake County Medical Society was asked to attend a meeting on the discussion of Dumbarton Oaks conference, in Hammond. The President also represents this auxiliary on the Executive Board of the Lake County Tuberculosis Association.

*Legislation:* We have been grateful for the efficient way in which our state legislative chairman has kept us informed on "State Legislation."

*Social:* One of the chief aims of the Auxiliary is to promote fellowship and friendship among its members. This year has been outstandingly successful in that respect, as is shown by the increased interest, gain in membership, and large attendance at meetings and social gatherings. The county spent some time revising its constitution and by-laws, making them correspond with the state and national constitution. It is felt that greater efficiency in committee work will be possible with the spread of responsibility to more members. We feel that Lake County has passed its infant stage and is ready to embark on a full-fledged auxiliary program.

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### LAPORTE COUNTY

Mrs. R. B. Engstrom, President

Officers were elected for two-year terms at the October meeting: Mrs. R. B. Engstrom, president; Mrs. C. W. Brown, vice-president; Mrs. M. D. Gardner, secretary; and Mrs. G. O. Larson, treasurer.

We have held meetings in October, September, January, and April. The women meet for dinner and discuss whatever business is necessary. At the April meeting we met with the men and heard their speaker, Doctor Sullivan, of the American Association of Physicians and Surgeons.

Letters were sent to the legislators, to indicate our support and rejection of certain medical bills presented before the legislature this session.

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### MADISON COUNTY

Mrs. Guy E. Ross, President

The Madison County Medical Auxiliary has held eight meetings to date, with an average attendance of fifteen. We have thirty paid-up memberships. There are nineteen members whose husbands are in the service and who are for the most part inactive.

Miss Hazel McGuiness, administrator at St. John's Hospital, gave a talk on the Nurses' Cadet Program, and explained it in detail. Mrs. Frank M. Gastineau, our state president, and Mrs. Charles F. Voyles, our state parliamentarian, were guests at a fall meeting. Usually the meetings have been social. However, as individuals the members have given their time to Red Cross work and the war services.


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**from Military Service should notify Company immediately.**

*MILITARY POLICY*

**does not cover Civilian Practice.**

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Three members have subscribed to the *Bulletin*, and twelve to *Hygeia*. This is the first year we have had any subscriptions.

---

### MARION COUNTY

Mrs. Henry S. Leonard, President

The following programs were given this year by the Woman's Auxiliary to the Marion County Medical Society:

On November 22, 1944, a Fashion Clinic and Tea was given in L. S. Ayres & Company Auditorium, with the Membership Committee in charge.

On January 15, 1945, at a meeting held at the City Hospital, the Legislative Committee was in charge. Mr. Thomas A. Hendricks, executive secretary to the Indiana State Medical Association, was the speaker.

March 5, 1945, a meeting was held in the Wm. H. Block Company Auditorium, with the Public Relations Committee in charge. The speakers at this meeting were Dr. A. F. Weyerbacher, who discussed "Adult Health and Its Relation to Juvenile Delinquency," and Mrs. James L. Bradley, referee of Juvenile Court, who discussed "Youth Steps Out." Representatives of various organizations in the city, interested in youth, were invited. About three hundred persons attended this meeting.

A luncheon was held at the Woman's Department Club, on May 4, 1945, followed by annual reports and the election of officers. The program chairman was in charge.

We followed the plan of scheduling our meetings on different days of the week, as some of our members have certain obligations for definite days during the month. In this way we made it possible for them to attend at least one meeting during the year.

Membership is now 181, as compared with last year's 162—increase of 19.

*Hygeia* subscriptions increased from 26 to 95—more than tripled.

*Bulletin* subscriptions now total 17, 6 old and 11 new.

War Service Committee Reports: 33,920 hours. Two hundred ten persons were contacted, and 180 participated.

We lost one member by death: Mrs. Edwin S. Knox.

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### MARSHALL COUNTY

Mrs. M. O. Klinger, President

Marshall County has eight members, and the average attendance for the eight meetings during the year was six.

Meetings of the year included a picnic at Culver; a book review, and a general meeting on the subject of "Red Cross Home Service."

We have eight subscriptions to the *Bulletin*.

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### NORTHEASTERN INDIANA ACADEMY OF MEDICINE

Mrs. C. E. Munk, President

The Woman's Auxiliary to the Northeastern Indiana Academy of Medicine has twenty members. Seven of our members have husbands in the armed forces. We have lost one member through death.

Two meetings were held, one social and one educational. Because we were unable to hold regular meetings, our members were urged to work as individuals for the auxiliary. A copy of the state auxiliary program was given to each member, to be used as a guide for study and for preparing medical programs for club use.

Three student nurses were recruited for the United States Cadet Nurse Corps. Two members taught classes in Home Nursing.

One member spoke on "Military Medicine" before a large group. One thousand dollars in War Bonds were sold. Nine eight-month subscriptions to *Hygeia* were sold, and we have one subscriber to the *Bulletin*. Our auxiliary pays the state and national dues for resident members whose husbands are in the armed forces.

### PORTER COUNTY

Mrs. A. J. Van Winkle, President

The Woman's Auxiliary to the Porter County Medical Society has fourteen members, and three whose husbands are in the service. There were seven regular metings, with an average attendance of seven. Meetings are held on the fourth Tuesday of each month except December. This is also the date of the meetings of the Porter County Medical Society. Each meeting includes a dinner at 6:30, with the business meeting and program following. The place is either at the home of a member or at Hotel Lembke.

Programs were devoted chiefly to a study of current Health, Education, and Legislative problems. Health films were shown at the Woman's Club meeting instead of the regular January meeting. Mrs. J. W. Mather, state public relations chairman, gave a very interesting talk at the March meeting, followed by a discussion by the members. The Porter County Auxiliary did not undertake any special war work program, but the members contributed to the war effort through other organizations.

*Hygeia* subscriptions numbered 15½, and there were 2 *Bulletin* subscriptions.

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### ST. JOSEPH COUNTY

Mrs. M. J. Thornton, President

Six meetings were held during October, November, January, February, April, and May. The meetings were social and included a book review; a musical program by the High School Glee Club Chorus; a talk on "Present-day Philosophy of Education;" and the election of officers in May. The organization sponsored *Hygeia* in all South Bend and Mishawaka schools and in the county high schools. We edited *The Bulletin* for our doctors in the service. A "Nurses' Scholarship Fund" is maintained, but due to the Cadet program it is now inactive. This year we have added a new committee of "Hospitality," whose function it is to contact newcomers and acquaint them with our auxiliary and city.

We have been of special assistance to the "service wives," and have provided entertainment for them financed by the medical society. There are seventy paid members. Only paid members are listed in our *Year Book*, which is mailed in October.

Forty-seven members gave 4,126 hours to the different war services.

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### SULLIVAN COUNTY

Mrs. F. M. Dukes, President

The Sullivan County Auxiliary has fifteen members. All members subscribed to *Hygeia*, and the auxiliary had one subscription to the *Bulletin*.

We turned in twenty-six subscriptions to *Hygeia*.

Two Afghans were completed and turned in to the Red Cross. Other war work was as follows:

War Mother's Club—60 hours.
Knitting—40 hours.
Surgical dressings—123 hours.
Red Cross—6 hours.

The auxiliary met seven times during the year.

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### TIPPECANOE COUNTY

Mrs. John B. Morrison, President

The women of the Tippecanoe County Auxiliary found it very difficult to meet during the busy winter. We held a luncheon meeting in October, with an attendance of sixteen members, and a dinner meeting in November, at which time it was voted to discontinue regular meetings

# METAMUCIL

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# SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

during the winter months. Many of those who otherwise would have been active in the organization were very busy with Red Cross work of all kinds, and as chairmen of other war activities. Without help in their homes, they felt that they could not do more outside than the war work. We are hoping to have our first meetings of the spring months in April, May, and June.

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### VANDERBURGH COUNTY

Mrs. Mell B. Welborn, President

September—Historical:
"History of the Woman's Auxiliary to the Vanderburgh County Medical Society," by Mrs. H. C. Ruddick.

October—Public Relations:
"The Neighborhood House," by Miss Luna Kenney and Miss Agnes Brinigar.

November—Social Meeting:
Luncheon and bridge at the Montgomery Spence Tearoom.

January—Parliamentary:
"Parliamentary Law," by Mrs. William Ehrich.

February—Medical:
"History of Chemical Medicine," by Rudolph Ellingston, Ph.D.

March—Social—(Cancelled because of flood).
Public Relations:
"Medicine in the Post-war World," by Dr. Morris Fishbein.

April—Health:
"Maternal Health," by Dr. Caroline Goodwin.

May—Open meeting to be arranged on "Child Welfare."

Projects for 1944-45:

1. Sponsored public meeting at which Dr. Morris Fishbein spoke on "Medicine in the Post-war World."
2. Participation in sale of Christmas seals for Tuberculosis Association.
3. Membership increased to seventy-eight.

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### VIGO COUNTY

Mrs. C. A. Curry, President

The Vigo County Auxiliary has sixty members, an increase of nine members over last year.

We have had five regular meetings. One meeting was called in April for the installation of new officers, thus enabling the president-elect to be present at the April state board meeting.

Our *Hygeia* chairman, Mrs. Riggs, with the cooperation of the medical society, has been able to secure sixty-three subscriptions—over 100 per cent. We have subscribed to four copies of the *Bulletin*.

Legislation was discussed at the executive meeting, and the chairman, Mrs. Blum, was authorized to send a telegram to our representative in protest of the osteopathic bill. A letter was sent to the City Council of Terre Haute, approving the passage of the bill for Grade "A" milk.

We were fortunate in having our state president, Mrs. Gastineau, and our state parliamentarian, Mrs. Voyles, with us for the October meeting.

At the November meeting, Mrs. Mattox reviewed the book "Anna and the King of Siam." In January we had a dinner and a book review, by Mrs. Arthur Cunningham. Our Public Relations meeting was in March, with Dr. Alfred Stanley lecturing on "Penicillin." At three of these meetings we had Red Cross sewing.

Our occupational therapy chairman, Mrs. L. A. Malone, has made several informative and highly-interesting talks before women's clubs and church organizations. We have an outpatient clinic in conjunction with occupational therapy at both hospitals. To pay our part of the therapists' salary, we held a rummage sale last fall.

We received citations for work in War Bond drives.

# Books

## BOOKS RECEIVED

**TRAUMA IN INTERNAL DISEASES.** With Consideration of Experimental Pathology and Medicolegal Aspects. By Rudolph A. Stern, M.D., Assistant Physician, City Hospital, New York City. 575 pages. Cloth. Price $6.75. Grune & Stratton, Inc., New York, 1945.

**CONSTITUTION AND DISEASE.** Applied Constitutional Pathology. (Second Edition.) By Julius Bauer, M.D., Professor of Clinical Medicine, College of Medical Evangelists, Los Angeles. 247 pages. Cloth. Price $4.00. Grune & Stratton, Inc., New York, 1945.

**CLINICAL ROENTGENOLOGY OF THE DIGESTIVE TRACT.** (Second Edition.) By Maurice Feldman, M.D., Assistant Professor of Gastroenterology, University of Maryland. 769 pages with 551 illustrations. Cloth. Price $7.00. The Williams & Wilkins Company, Baltimore, 1945.

**PENICILLIN THERAPY.** Including Tyrothricin and Other Antibiotic Therapy. By John A. Kolmer, M.D., Professor of Medicine in the School of Medicine and the School of Denistry, Temple University; Director of the Research Institute of Cutaneous Medicine. 302 pages with 22 illustrations. Fabrikoid. D. Appleton-Century Company, Incorporated, New York, 1945.

**TECHNICAL METHODS FOR THE TECHNICIAN.** By Anson Lee Brown, M.D., Director of Dr. Brown's Clinical Laboratory and School for Technicians, Columbus, Ohio. 706 pages with 229 illustrations. Fabrikoid. Price $10.00. B-B Printing Company, Columbus, 1944.

## REVIEWED

**PSYCHOANALYSIS TODAY.** Edited by Sandor Lorand, M.D., 404 pages. Cloth. Price $6.00. International University Press, 1944.

*Psychoanalysis Today* is a series of chapters by different authors, edited by Sandor Lorand, M.D. Doctor Lorand has in this work given us a number of articles by men of high repute on the subject. It is of value chiefly in that it tells us what may be expected as a result of the application of this method of treatment in different psychiatric problems. The chapter on "War Neurosis" is particularly pertinent at the moment. For the most part the writing is in a language which does not send the average man to his medical dictionary every few sentences. Some few chapters do not read so readily, but those that do (and these are in a preponderant majority) make up for the ones that are too technical.

MINOR MILLER.

**DOCTORS AT WAR.** Edited by Morris Fishbein, M.D., editor of The Journal of the American Medical Association. 418 pages with numerous illustrations. Cloth. Price $5.00. E. P. Dutton & Company, New York, 1945.

As war clouds gathered over the national horizons in 1940 the American Medical Association foresaw the need for medical preparedness and took official action. *Doctors at War* is a review of some of the developments of World War II.

The unprecedented expansion of our armed forces meant the need for a great number of doctors. At the same time an equitable distribution of doctors at home had to be maintained. Doctors were enrolled and classified. The Procurement and Assignment Service for Physicians, Dentists, and Veterinarians was created, leaving

procurement to the professions themselves. To meet the emergency more doctors were needed. The medical college curriculum was speeded up and condensed.

Examination of men by doctors revealed astounding facts. Of the first two million men examined by Selectice Service, one million were rejected. Yet the victories won by the American troops all over the world were not won by weaklings. Physical fitness means more than big muscles. In medical science Ehrlich's technique in the discovery of salvarsan resulted in the evolution of the sulfa drugs, of which forty tons have been shipped overseas every three months. Out of the war has come penicillin, gramicidin, and tyrothricin; availability of blood banks and plasma to men on battlefronts; mass production of atabrine tablets shipped by the billions to our British, Russian, and Chinese allies; and DDT which stopped typhus, which was epidemic in Naples when our troops arrived there.

By 1944, ten million insect bombs had been produced, each with sufficient spray for one hundred and fifty pup tents or fifty giant bombers.

In June, 1940, our Army had 1,578 medical officers; by 1944, it had 40,200.

The matter of rank and promotion in the Army has been a headache, both to the Surgeon General's Office and the doctor. It is satisfactorily explained.

In war, supply is an essential factor. Our lines of communications extend over fifty-six thousand miles.

In logistics, beyond the consumer lies the problem of wholesale production and the evolving of new items.

In the Surgeon General's Office the Division of Preventive Medicine provided against many diseases not common to the United States.

By 1944 the Navy Department medical personnel numbered more than that of the whole Navy in 1939. In 1942 the Navy sent to the Southwest Pacific the first mobile unit, with eighteen doctors, two dentists, and three hundred corpsmen. This unit unloaded forty thousand tons of equipment without injury to a single man. Of its first ten thousand cases it had a mortality rate of one-third of one per cent.

As of March 31, 1944, 55 per cent of all sailors and marines wounded since Pearl Harbor had been returned to duty. Of the remaining 40 per cent still under treatment many would be returned to duty.

The chapter on "Aviation Medicine" is classic. The genius of those responsible for the selection and training of pilots, navigators, and bombardiers inspires universal admiration. This chapter portrays the astounding fact that the men of the air rise to the point of successfully meeting the physical, mental, spiritual, and psychological levels required of them.

Of equal importance is the genius that develops and produces the protective safety devices so essential to aerial warfare. In combat, airmen find themselves in the bizarre situation of intense concentration amid intense distraction when the fear of death becomes very real.

This book reminds us that when all efforts to select and train men for high-altitude life are exhausted, there still remains the human being and not an aerial automaton. There is no device for fortifying or insulating his central nervous system against the impact of fear and fatigue in combat. Good leadership is a prophylactic; the flight surgeon is a big factor in the leadership-morale equasion. The marvels of evacuation by air are as romantic as any book of fiction.

*Doctors at War* is an intimate, sincere, and authentic presentation of a record during World War II of which we justly may be proud. It is divided into sixteen chapters. The reader will gather an insight into the part science and industry have played; the conception and magnitude of a global war; the challenge to the imagination and initiative of the peacetime soldier who planned the organization and training of men at home, and then in war led them in battle; and of the contributions of a "decadent democracy" to the winning of the war.

CHARLES R. BIRD, M.D.

## ABSTRACTS

### PENICILLIN IS USED IN TREATMENT OF FUNGOUS DISEASE

Penicillin has proved successful in the treatment of actinomycosis, a chronic infectious disease which usually affects the face and neck, two physicians report in *The Journal of the American Medical Association* for June 9. Actinomycosis, which may be acquired from an infected shaving brush, is caused by a fungus. No uniformly satisfactory method of treatment has been found. Before the availability of the sulfonamides and penicillin, surgery was almost always necessary, healing was slow, and conspicuous scars were left.

Glenn G. Hendrickson, M.D., and Edwin P. Lehman, M.D., Charlottesville, Virginia, report two cases of proved actinomycosis of the face and neck, which were successfully treated with penicillin without any surgical drainage.

In one case a dose of penicillin was given into the vein every twenty-four hours, and twice penicillin in solution was injected directly into the diseased mass. The treatment lasted sixteen days.

In a second case penicillin treatment lasted fifteen days. Four days after the initial dose the infected area was less hard and tender. After the end of the second week the drainage ceased.

"These two cases," the authors explain, "are presented to indicate that certainly in some instances actinomycosis may yield to penicillin without the necessity for painful and deforming surgical procedure."

### LIQUIDS AND NUTRITION VITAL IN TREATMENT OF MOST BURNS

Since severe burns result in a great loss of fluids in the body, treatment should include the immediate administration of liquids as an important adjunct to the actual care and dressing of the burns themselves, it is pointed out in *The Journal of the American Medical Association* for June 16.

The advice is contained in a memorandum prepared for medical officers by a subcommittee of the National Research Council and the Office of Scientific Research and Development. The committee is composed of five physicians: Henry N. Harkins, Chairman, Baltimore; Oliver Cope, Boston; Everett I. Evans, Richmond, Virginia; Lieutenant Commander R. A. Phillips (MC), U.S.N.R., New York, and Dickinson W. Richards, Jr., New York.

Accompanying the fluid and nutritional therapy, local burn treatment, the article said, should include injections of penicillin and administration by mouth of sulfonamides for the prevention and control of burn sepsis or poisoning. Since burns which cover less than 10 per cent of the body surface do not involve too much loss of fluid, the intensive treatment with liquids is intended for patients with more than 10 per cent of the body surface involved by second degree or third degree burns.

Fluid therapy or treatment in burns should aim toward rapid replacement of the acute fluid deficit and also the maintenance of daily needs. Blood plasma and whole blood are administered by vein both to restore blood volume and to treat shock, a condition that results in a general slowing up of the entire blood circulation. When plasma is not available, whole blood is better than any salt or glucose solutions administered by vein. The physicians caution, however, that whenever transfusion reactions occur from whole blood after repeated transfusion, the patient's blood should be typed for the Rh factor.

Fluid administration by mouth should be started immediately on admission of the patient to the hospital, before local dressing treatment is begun and while the patient is waiting for the administration of whole blood or blood plasma by vein. A definite schedule for giving the fluids should be set up and closely followed to avoid

overloading the stomach. In severe cases of shock the fluids should be given cautiously, as absorption may be slow. In the aged or heart patient, if too much fluid is given there is danger of pulmonary edema, a condition in which fluid escapes into the lungs with ensuing suffocation. Obviously, at the beginning of the treatment the fluids administered will pass into the dehydrated and injured tissues, and the urinary output will be small. The urinary output is one important indication of the adequacy of fluid treatment, and kidney damage may result if the body poisons are not eliminated.

The problem of feeding during the often prolonged period of infection and anemia is immensely important. Each case is an individual problem of dietetics and nursing. A full food intake, with high caloric value, vitamins and especially protein, is essential.

## INDIANA STATE BOARD OF HEALTH

### DIVISION OF COMMUNICABLE DISEASE CONTROL

### Monthly Report—March, 1945

| *Diseases* | *March 1945* | *Feb. 1945* | *Jan. 1945* | *March 1944* | *March 1943* |
|---|---|---|---|---|---|
| Chickenpox | 529 | 480 | 563 | 661 | 442 |
| Measles | 142 | 49 | 27 | 1103 | 1356 |
| Scarlet Fever | 782 | 717 | 521 | 848 | 387 |
| Smallpox | 10 | 6 | 6 | 3 | 16 |
| Typhoid Fever | 10 | 2 | 4 | 16 | 6 |
| Whooping Cough | 60 | 73 | 54 | 67 | 182 |
| Diphtheria | 39 | 33 | 24 | 33 | 20 |
| Influenza | 54 | 39 | 28 | 52 | 53 |
| Pneumonia | 23 | 13 | 13 | 40 | 78 |
| Mumps | 456 | 278 | 220 | 238 | 326 |
| Poliomyelitis | 2 | 1 | 3 | 1 | 0 |
| Cerebrospinal Meningitis | 19 | 12 | 19 | 37 | 26 |
| Rubella | 9 | 0 | 4 | 14 | 898 |
| Erysipelas | 1 | 0 | 1 | 1 | 1 |
| Undulant Fever | 1 | 6 | 11 | 5 | 1 |
| Malaria, Acquired outside U.S. | 2 | 0 | 1 | 0 | 0 |
| Infectious Conjunctivitis | 2 | 0 | 0 | 0 | 0 |
| Septic Sore Throat | 6 | 10 | 0 | 23 | 0 |
| Infectious Jaundice | 3 | 0 | 0 | 3 | 0 |
| Tuberculosis, Pulmonary | 426 | 154 | 215 | 146 | 200 |
| Tuberculosis, Other Forms | 7 | 10 | 10 | 0 | 25 |

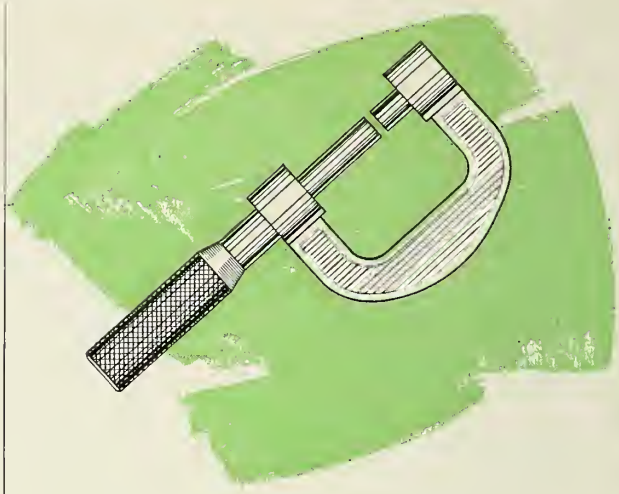
## INDIANA STATE BOARD OF HEALTH

### DIVISION OF COMMUNICABLE DISEASE CONTROL

### Monthly Report—April, 1945

| *DISEASES* | *April 1945* | *March 1945* | *Feb. 1945* | *April 1944* | *April 1943* |
|---|---|---|---|---|---|
| Chickenpox | 257 | 529 | 480 | 592 | 507 |
| Measles | 106 | 142 | 49 | 1185 | 2103 |
| Scarlet Fever | 451 | 782 | 717 | 972 | 345 |
| Smallpox | 7 | 10 | 6 | 2 | 5 |
| Typhoid Fever | 10 | 10 | 2 | 6 | 0 |
| Whooping Cough | 43 | 60 | 73 | 49 | 330 |
| Diphtheria | 16 | 39 | 33 | 23 | 16 |
| Influenza | 4 | 54 | 39 | 24 | 141 |
| Pneumonia | 11 | 23 | 13 | 27 | 48 |
| Mumps | 280 | 456 | 278 | 268 | 411 |
| Cerebrospinal Meningitis | 14 | 19 | 12 | 38 | 39 |
| Nonepidemic Meningitis | 1 | 0 | 0 | 1 | 1 |
| Trachoma | 2 | 0 | 4 | 0 | 0 |
| Septic Sore Throat | 8 | 6 | 10 | 25 | 0 |
| Impetigo | 3 | 0 | 2 | 0 | 0 |
| Undulant Fever | 4 | 1 | 6 | 6 | 8 |
| Erysipelas | 3 | 1 | 0 | 1 | 0 |
| Rubella | 8 | 9 | 0 | 29 | 1347 |
| Silicosis | 1 | 0 | 0 | 0 | 0 |
| Malaria, Acquired Outside U. S. | 1 | 2 | 0 | 4* | 2* |
| Tetanus | 1 | 0 | 0 | 0 | 0 |
| Infectious Jaundice | 3 | 3 | 0 | 0 | 0 |
| Tuberculosis, Pulmonary | 259 | 426 | 154 | 255 | 222 |
| Tuberculosis, Other Forms. | 7 | 7 | 10 | 3 | 29 |

* Not classified as to whether it was acquired inside or outside of the United States.

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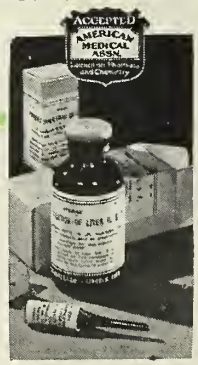
PURIFIED SOLUTION OF




## Liver
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# THE JOURNAL
OF THE
# INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

*ISSUED MONTHLY under Direction of the Council*

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 38 AUGUST, 1945 Number 8

## MEDICAL EDUCATION*

W. D. GATCH, M.D.

Dean, Indiana University School of Medicine

INDIANAPOLIS

This occasion requires a talk on a subject related to the general welfare of our profession. "Medical Education" meets this requirement. The future of medicine depends upon it. I contend that it should start with premedical studies and continue throughout professional life.

Scientific medicine is young—not yet a hundred years old. Gross anatomy and gross pathology were the only medical subjects a hundred years ago which could be called scientific. The art of medicine, however, is thousands of years old. Its essential principles were stated over two thousand years ago in the Hippocratic Oath. This requires us to keep secret any knowledge we have of our patients; not to teach medicine to the laity; to treat our fellow practitioners fairly; and, finally, to teach medicine to all properly-qualified students. Medical teaching is, therefore, an ancient practice of our profession. For ages every physician was a teacher. The would-be student of medicine selected some experienced physician as a preceptor under whom he was said to "read." The student helped his preceptor make professional calls, assisted him at operations, and in the preparation of medicines. This plan worked very well as long as medicine was almost entirely an art. It persisted in the United States into the early part of the present century. The rapid accumulation of scientific knowledge in the latter half of the nineteenth century made a more formal plan of instruction necessary. Great numbers of medical schools were founded to meet this need. Most of these were the private property of their faculties, and were poorly equipped for teaching. They were subject to no regulation, and their educational standards were not high. The American Medical Association, in 1908, started the regulation of medical education on a nation-wide basis by prescribing minimal standards for acceptable medical schools. This action greatly reduced the number of medical schools. Today only sixty-nine recognized schools exist. The regulation of medical education since 1908 has become more and more stringent. The governing bodies are the Council on Medical Education and Hospitals of the American Medical Association, the Association of American Medical Colleges, the American College of Surgeons, the American College of Physicians, the state boards of medical examination and registration, the association of the various specialties, and the national boards of examiners for the various specialties.

We may well wonder whether or not this regulation has been carried too far. It prescribes at least two years of premedical education, four years of undergraduate medical education, and one year of intern training — seven years before the student can begin practice. Students who wish to enter the specialties must spend at least three years more in postgraduate studies before they can take their national board examination. Society is demanding a great deal of the student when it asks him to devote from seven to twelve of the best years of his life to the study of medicine. The cost of medical education to the student is appalling. We must include in this the direct costs of tuition, books, instruments, and living, and the indirect cost of what the student loses while in school by not working in gainful employment. Twenty thousand dollars is a low estimate of the cost of a minimal medical education today.

* Address given before the Eighth Councilor District of the Indiana State Medical Association, at Winchester, on June 13, 1945.

Careful studies made before the war showed that we had enough physicians in the United States to give its people all necessary medical care if the distribution of physicians had not been faulty. We had too many physicians in the cities, and not enough in many rural districts. The armed services have now taken from practice some fifty-five thousand physicians. A scarcity of physicians now exists everywhere. This has caused a demand, which has considerable public support, that medical schools increase their number of graduates. This cannot be done without lowering standards. Doctor Fishbein has shown that before the war every student who wished to study medicine, who had the ability to meet the standards of admission to medical school, and who could make the necessary sacrifice of time and money could be admitted to an approved medical school. It takes a stout-hearted man to face the prospects of spending at least twenty thousand dollars, of devoting at least seven years to gruelling study, and of postponing the beginning of a settled life for perhaps ten to twelve years. Probably not more than six thousand men a year, in the whole country, are able to meet these conditions. The experience of the Admissions Committee of our own school supports Doctor Fishbein's conclusions.

The medical schools and various regulating agencies were gradually working out a solution of the difficult problems of medical education and of the related problems of hospital management and general medical care when the war broke out. This has had a revolutionary effect on medical education. It has taken from the faculties of the medical schools most teachers under fifty. It has placed the schools under military control. It has forced them to keep open continuously. It has made the management of their associated hospitals extremely difficult. It has cut the intern year to nine months. It has practically abolished postgraduate study. Most medical educators believe that it has caused a disastrous lowering of educational standards. I am inclined to agree only in part with this opinion. It fails to consider the fact that without government regulation and support the medical schools would have been compelled to close. I have found the Army officers in command of our students to be very cooperative, and not inclined to interfere at all with the regularly-prescribed work of the school. I believe that our students do at least as well in their studies as students did in prewar days. Army regulation has introduced a powerful force of compulsion into medical education. The knowledge that failure to pass means separation from the unit is a strong incentive to study.

We must endure the crippling of research, limitation of the number of interns and residents, and cessation of postgraduate instruction as unavoidable evils of war. I condemn entirely only one government regulation—that is the Selective Service ruling that premedical students cannot be exempted from military duty. This has already diminished the supply of medical students. Next year it will have reduced the number of first-year students in the country by two-thirds. This regulation seems to have been unnecessary in view of the small number of men who would have had to be exempted for premedical studies. Even this situation, however, is not entirely without beneficial effect, because it will enable the medical schools to give more time to postgraduate instruction of physicians coming home from war.

The accelerated program of instruction and the loss of teachers have forced the faculties of medical schools to re-study their curriculum. This indirect effect of military regulation of medical education may ultimately more than compensate for all possible injuries military regulation has caused it. I have already spoken of the long time required for medical education. Could not equally good results be obtained in less time? I believe that by revision of the curriculum and improvement in methods of instruction this can be accomplished. The present curriculum of most schools is overloaded with antiquated material which is now of historical importance only. Basic sciences are too often taught without regard to their relation to clinical medicine. Men who have had no clinical experience teach the students many facts of little or no clinical importance, and fail to teach them facts of great clinical importance. A gulf separates preclinical from clinical studies. The student of medicine now spends four to five years in college and medical school before he sees a patient. That is wrong. The first-year medical student should be brought into direct contact with the patient. He should be taught those parts of anatomy, physiology, biology, and chemistry which are of direct importance to clinical medicine. He would remember these basic sciences if he were made to see from the beginning that a knowledge of them is essential to the successful performance of his life work. He forgets them under the present system and has to re-learn them later. Preclinical medical instruction also needs overhauling. A student of medicine is not fitting himself for life work as a zoologist, chemist, or physicist. Instruction in these subjects should be adapted to the student's needs as a physician. The premedical student needs more instruction in English than he usually gets.

Undergraduate medical instruction is really postgraduate instruction. The student, by the time he has reached his second year, has had at least three and often four years of college work. He is not fit to continue the study of medicine if he is still incapable of self-direction. High school and even college methods of instruction do not meet his needs. He should be required to get information on assigned subjects from the literature. His progress should be tested by quizzes and conferences at which the instructor meets and carries on informal discussions with a small group of students. The number of lectures given to the entire class should be limited. Free use should be made of motion pictures and other forms of visual instruction. Students should be encouraged to teach one another. Compre-

hensive oral examinations should be given frequently; also practical achievement tests. Sharp divisions of instruction among the departments of the medical school should be done away with; for example, anatomy, physiology, pathology, symptomatology and treatment should be taught together so that various parts of the teaching are closely associated in the student's mind and easily remembered. The conduct of this method of instruction requires a large number of teachers. This may seem to make its cost prohibitive. Such is not the case, because a large number of the best possible teachers are always available in the resident staff of the medical schools' hospitals. These residents are preparing for their national board examinations in both clinical and basic studies. The best possible way for them to learn these subjects is to teach them. I believe that our medical schools should greatly increase the time they spend on examinations.

So-called "postgraduate instruction" begins with the intern year. This is probably the most important period of the medical student's education. In it he first meets the responsibility of caring for the sick. He here learns to apply the vast quantity of knowledge he has presumably acquired in his undergraduate years. He learns what a modern physician must know about hospital management, and the proper use of medical specialists. Here, too, he must discover, with the aid of his supervisors, what kind of medical practice he should in the future pursue. The intern year is the great sorting period for medical students.

What constitutes a good internship? Certainly not one in which the student is used, without proper guidance or instruction, almost entirely in the routine care of patients for the benefit of the hospital and its staff. The intern has an obligation to the hospital to do a reasonable amount of routine work, but he has a right to expect that the hospital will in return further his professional skill and knowledge. Medical graduates more and more are refusing to accept internships in hospitals which will not do this for them. They demand that the hospital be a teaching institution.

Interns who decide to fit themselves for a special line of practice seek residencies in hospitals authorized by the American Medical Association and other regulating agencies to give resident training. This training must fit them to take a gruelling and comprehensive national board examination which covers the basic sciences and the entire subject matter of the specialty. The national board examination is both theoretical and practical. The applicant must produce evidence of thorough and prolonged clinical experience in addition to possession of the required theoretical knowledge. The number of hospitals permitted to train specialists is limited. The demand for specialist training is almost unlimited. This is a weakness in our facility for teaching medicine, which I shall discuss later.

I cannot at this point omit repeating what I have said time and time before about the interns who for one reason or another do not take residencies to fit them for a special line of practice, who, in other words, go out into general practice. A questionnaire on postgraduate training which I recently received from the American Medical Association lists thirty separate specialties—almost half of them surgical. Specialization is no longer conditioned entirely by anatomy. We now have specialists on diseases or agents which may harm any part of the body; for example, specialists on cancer. Specialization is an inevitable result of increasing knowledge. The techniques required in a given field of work may be so complicated and its problems of diagnosis and treatment so difficult as to make necessary its establishment as a necessary specialty. We cannot get along without specialists, but we could certainly get along with fewer specialists than we now have. (Thirty per cent of all physicians in the United States are now listed as specialists.) The specialist has merits, but he often has serious limitations. Some of these are:

1. Overestimation of the importance in defects he discovers in the special organs to which his view is confined.
2. Inability to treat the entire patient as a complex, psychophysical organism.
3. A narrowness of outlook—the result of a too early withdrawal from the main stream of medical thought. Many specialists almost cease to be physicians.

Specialists must practice in urban communities of some size. Overspecialization is therefore a chief cause of the faulty distribution of medical care.

Many writers on medical education and medical care have the idea that adequate medical care demands that every patient must have easy access to a large number of specialists. Some of them boldly assert that the day of the general practitioner is over. I am sorry to say that this opinion has been fostered by the policy of our medical organizations and medical schools. These have exalted the specialist and ignored the general practitioner, despite the fact that the general practitioner fills a social need which no one else can fill. Many things have fostered the cult of specialization; we enumate the more important of these:

1. The life of a specialist is comparatively easy. He usually can keep regular hours.
2. He is better paid than the general practitioner.
3. He is honored by the medical profession, by hospital managers, by the faculties of medical schools, and by the public.
4. He becomes a member of a special organization which advertises his merits and promotes his welfare.

The general practitioner, on the other hand, encounters many problems:

1. He must look after his patients at any hour of the day or night.
2. His income is greatly lower than that of the specialist.

3. He has no special state or national organization to look after his interests.
4. He has to know more than any specialist, because he has to know at least the fundamentals of all the specialties.
5. He must face the problem of living with his patients and dealing with them from day to day.

Anyone who has had extensive experience in the care of the sick and who will read the writings of those who seek to revolutionize our entire plan of medical care must make the observation that very few of these theorists have had any experience in the actual care of the sick. They do not realize that money alone cannot purchase good medical care; that medical care furnished entirely by groups of medical specialists would be expensive and terrible; and, finally, that no one can take the place of a competent general practitioner. Dr. Dean Lewis once remarked that the cult of specialization had been fostered by the doctrine that every patient who comes to a doctor requires a complete examination. Some patients undoubtedly do demand complete and exhaustive study, but to subject every patient to this would make the cost of medical care prohibitive, and this practice would undoubtedly create more mental and physical ills than it would discover or correct. It would make us a nation of hypochondriacs. At least half of the complaints for which patients consult physicians are due to imaginary ills. Specialists too often aggravate the fears of patients. The general practitioner who knows intimately the personal and family history of his patients, who can see them from day to day, can manage this fifty per cent of medical practice better than anyone else can hope to do.

The foregoing considerations force us to several conclusions:

1. That our present method of training general practitioners is woefully inadequate.
2. That we should do everything possible to help and encourage these downtrodden but indispensable members of the profession.
3. That the number of specialists should be determined by the actual need of the public for their services, and not by the desire of interns to become specialists. I remark in passing that our national boards can bring about this reform.

Many questions suggest themselves along this line of thought. What special training should the general practitioner have? Should he not be certified to the public as a specialist? What are the limits of internal medicine and general surgery?

I will now consider postgraduate education of men in general and special practice. This is the most poorly-developed part of medical education, and is the part in most serious need of study. Its problems are difficult, and no satisfactory solution thereof has yet been found. Present plans for this important part of medical education are little more than makeshifts. What are these plans? There are in reality only two:

1. Instruction by lectures or by clinics. This form of instruction may be brought to the students in their home communities, or it may be given them at meetings of short or long duration at places away from their homes.
2. Intensive courses on various subjects offered at medical centers.

Both plans of instruction are poor, although the second is somewhat better than the first. Both methods have that most serious vice of medical instruction—spoon-feeding. Neither of them demands continuous work by the student himself. Neither of them provides for any test of what the student has learned. The general atmosphere of a medical meeting is not one which favors serious scientific study. It favors relaxation and social enjoyment. This is no criticism of medical meetings. It is simply a statement of the obvious fact that the average physician does not get much useful medical education therefrom. Very few physicians can attend any but short courses of instruction given at medical centers, because they cannot leave home for an extended period of time.

What are the requirements of a satisfactory plan of postgraduate education? We may list the following:

1. Continuous study.
2. Facilities for this study at home.
3. Encouragement to study, and adequate direction of study.

These requirements are not difficult to meet. Every community hospital having one hundred beds or more can meet them. This, I believe, is the only satisfactory solution of the problem. It is a solution which the war has forced upon us. Physicians returning from military service will demand postgraduate instruction. The younger men whose training was cut short by military duty will be most insistent in demanding opportunities for worth-while postgraduate training. The medical schools cannot possibly meet this demand. They cannot increase the number of residencies they already have, because if they do it will decrease the value of the residencies. New residencies must be created in community hospitals. To do this every community hospital must become a teaching center. You will, no doubt, be interested to know that our own school has tried out this plan on an experimental basis at the St. Elizabeth's Hospital, in Lafayette, by invitation of the Tippecanoe County Medical Society. The medical school has started an extension course at this hospital. It furnishes anatomical material and teachers of anatomy and applied physiology. It also sends an instructor once a month to conduct a conference on some assigned study. The hospital has installed a good working library, and the staff of the hospital has organized itself into a faculty for the mutual instruction of its members and of its interns and residents. So

far this plan has worked very well. Its success demands that the hospital staff be well organized, harmonious, and interested in teaching. A plan of this kind is certain to benefit the men who participate in it. It increases their knowledge and ability as practitioners. It promotes harmony and cooperation among them. It is sure to improve the medical care of the people of the community, and by so doing increase the respect of the community for its physicians. The plan represents a return to the ancient practice of our profession of making every physician a teacher. Hospitals which adopt this or a similar plan should be able to qualify for the instruction of residents in various subjects. They should also be able to obtain interns. Their work will be improved by the teaching which they sponsor. Finally, the physicians of the community united in a serious effort of this kind should be in a better position to influence and direct lay opinion on medical care. They should be able to see to it that the public receives proper and truthful instruction on medical subjects.

The plan I have just outlined has been supported by the American College of Surgeons and the American Medical Association. It offers, I believe, the only satisfactory solution to this difficult problem of postgraduate instruction of physicians.

It would do much to return medical education to physicians in practice. Its success demands work—there is no easy road to medical knowledge.

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# A METHOD OF TREATMENT OF FRACTURES OF THE MANDIBLE WITHOUT DENTURE

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Most of the principles in the treatment of fractures today were established in the war of 1917—the external fixation methods of fracture treatments started early in this period, but it was not until Roger Anderson's work that external fixation of fractures really came into extensive use.

Converse and Waknitz, in 1940, came out with the converging pin, Anderson type of appliance, which they originally used on fracture of the metacarpals, and now has been put into use on mandibular fractures. He found it particularly valuable in edentulous patients. The Stader splint is another external fixation appliance which in principle works in the same manner as the Waknitz splint. The Gunning vulcanite intermaxillary splint, supplemented with a snug head bandage, is also in extensive use in jaw fractures of patients without teeth.

Infections, ulceration of the skin, and failure to insert the pins correctly are the most common drawbacks to the external fixation techniques. In experienced hands the results are very satisfactory.

Since 1936 we have been using a technique in treating fractures of the mandible in edentulous patients which we believe is worthy of mention. The procedure is very simple, and no experienced ability is necessary for its use.

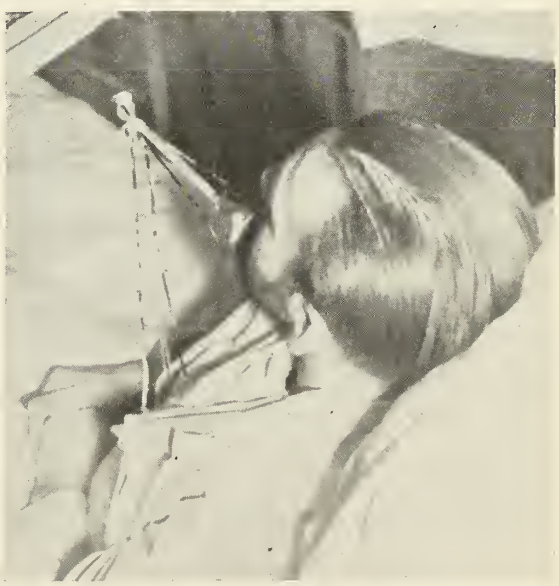
*Material needed:*

| | |
|---|---|
| Novocain | Silk suture |
| Syringe | Coat-hanger wire |
| Cubbins, et al, picture hook | Plaster cast |
| | Rubber bands |
| Knife | Hand drill and bit |

*Technique of procedure:*

Local infiltration with 1 per cent novocain of area of soft tissue, through to the bone, is done over the symphysis of the mandible. A vertical incision, about three-fourths of an inch long, is made over the area of infiltration down to the periosteum, which is then elevated and retracted. A small hole is made with a hand drill, with a one-eighth inch drill bit, through the bone in this

FIGURE 1



"Picture Screw" Traction with Rubber Bands

FIGURE II

*Skeletal Traction with Coat Hanger Incorporated*

region, and following this the picture hook is screwed into place at right angles to the symphysis. The incision is then closed, and the patient is ready for application of a body cast. The cast extends over the entire chest, leaving the neck and upper extremities free for motion. Four coat-hanger wires are incorporated in the cast and protrude upward and outward so that they come together at a point three inches from the hook attached to the symphysis. Rubber bands are then placed in position between the hook and the traction apparatus, with the pull at right angles to the symphysis, and the procedure is complete. (See Figures I, II and III.)

The patient remains in the appliance from six to eight weeks, depending upon callous formation at the site of fracture, as determined by x-ray follow-up. All during this period the patient is up and about, and is fairly comfortable. He has good motion of the lower jaw, is able to eat rather freely, talks without much difficulty, and conditions in general are quite favorable for the patient.

After the six- to eight-week period is up, the appliance is removed, and the opening from which the hook is removed closes off by granulation. This method of treatment cannot be used in cases where the fracture of the jaw involves the symphysis.

*Case No. 1:*

Mr. F. J., a thirty-nine-year-old, white male was struck in the jaw one or more times in an altercation in the office at the plant where he was working, and suffered a badly-comminuted fracture with displacement of the left mandible, and a simple transverse fracture of the right mandible without displacement. Seven days after the injury the patient was taken to surgery, where the appliance as described and illustrated above was applied. It was removed after six weeks, and the patient was back to work one week later, when the opening over the symphysis was walled off by granulation tissue.

*Case No. 2:*

Mr. W. B., twenty-five years of age, suffered a comminuted fracture of the right mandible, with much displacement following an automobile accident. Nine days after injury patient was taken to surgery and same application of extension as described above was applied. Forty-one days afterwards the appliance was removed, and the patient returned to work ten days thereafter.

**Conclusion:**

To date we have had six cases treated as described above in which the patient originally had no teeth, or had them damaged or lost at the time of the injury. All cases up until the present time have had satisfactory results. There has been no deformity and very little loss of function of the lower jaw after the completion of treatment. The procedure is very simple, and the appliance is applied without any special technique whatsoever. It should be of service to physicians who have not as yet mastered the use of the Stader or Waknitz external fixation methods of treatment.

FIGURE III

*X-Ray Reproduction Showing Reduction of Fragments*

# RESUMÉ OF EIGHT HUNDRED CASES OF EARLY SYPHILIS TREATED BY FIVE-DAY, SLOW-DRIP METHOD

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The meteoric brilliance of penicillin with all its reported promise in syphilo-therapy has overshadowed all else temporarily. There is no doubt but that it will be an outstanding addition to our therapeutic armamentarium, but not enough time has elapsed for prolonged observation as to its true evaluation with reference to proper dosage, mode of use, and the type of case for which it is especially indicated, or its ultimate results. However, we feel that it is also timely to offer further data on other advances in syphilo-therapy, namely, the massive five-day, slow-drip method. Although consolidated group reports,[1, 2] including ours,[3] have been published, we are herewith submitting a supplementary analysis on eight hundred cases of our own series, some followed up to a fifty-four month post-treatment period.

Our figures are not on a corrected basis such as some former group study reports,[1, 3, 4] but were actual at time noted. They even then closely approximate them, or are somewhat better in our own first eight hundred cases here reported.

Physical examination; routine flat chest plates; daily urinalysis, chemical and microscopic; complete blood count; urobilinogen daily; urea clearance; serum bilirubin, and multiple rechecked serologic tests as well as darkfields, when possible, are made on all patients. Weekly follow-ups with serology the first month, monthly for the first six months, and three to six months afterwards are scheduled. Spinal fluid examination is made pre- or post-treatment, and rechecked at six or twelve months. Most patients are held at least two days after completion of therapy. Our patients, with a few exceptions such as early latent in a few pregnancies, have all been in active infectious primary or early secondary clinical syphilis, all darkfield or sero-positive, or both.

Early in our series patients received only a total of 1200 mg. arsenoxide (mapharsen), or 240 mg. daily, in 2000 cc. of 5 per cent dextrose in distilled water for five consecutive days. Somewhat later sero-positive cases were given combined therapy with soluble bismuth in the form of thio-bismol (76 mg. metallic bismuth per cc.) on alternate days, or bismuth cevitamate (20 mg. metallic bismuth) daily while hospitalized. Later all cases received arsenoxide, 1000 to 1200 mg. total (weight-dosage ratio) in five days, plus insoluble bismuth subsalicylate on the first, fourth, and eighth day, estimating one intramuscular pre- and one post-treatment of hospital stay.

The following dosages were received:

| | |
|---|---|
| 1200 mg. arsenoxide (mapharsen) only | 228 |
| 1200 mg. arsenoxide (mapharsen) plus bismuth | 400 |
| Under 1200 mg. arsenoxide (mapharsen) only | 2 |
| Under 1200 mg. arsenoxide (mapharsen) plus bismuth | 170 |
| Total | 800 |

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[1] Hyman, Harold; Leifer, William; Elliott, David, et al: An Evaluation of the Massive Dose Therapy of Early Syphilis, *J.A.M.A.*, **117**:1154-1166 (Oct. 4), 1941.

[2] Elliott, David C., et al: USPHS Evaluation of Massive Arsenotherapy for Syphilis, *Venereal Disease Information*, Cooperating Clinics of New York and Midwestern Group, **25**:323, No. 11, (Nov.) 1944.

[3] Bowman, George W., and Sheehan, Francis G.: Massive Arsenotherapy in Syphilis, *J.I.S.M.A.*, **34**:665-669, No. 12, (Dec.) 1941.

[4] USPHS Evaluation: Massive Arseno-therapy for Syphilis, *J.A.M.A.*, **126**:554, No. 9, (Oct. 28) 1944.

**TABLE I**

**CASES NO. 1 TO 800, INCLUSIVE**

| *Color* | *Ages* | | | | | | | *Sex* | | | *Marital Status* | | | | *Stage of Syphilis* | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | —21 | 21-24 | 25-29 | 30-39 | 40-49 | 50+ | Total | Male | Female | Total | M. | S. | Other | Total | SI— | SI+ | SII | Total |
| White | 139 | 106 | 63 | 54 | 13 | 1 | 376 | 140 | 236 | 376 | 126 | 142 | 108 | 376 | 23 | 90 | 263 | 376 |
| Colored | 205 | 123 | 60 | 32 | 4 | 0 | 424 | 194 | 230 | 424 | 90 | 263 | 71 | 424 | 33 | 116 | 275 | 424 |
| Total | 344 | 229 | 123 | 86 | 17 | 1 | 800 | 334 | 466 | 800 | 216 | 405 | 179 | 800 | 56* | 206† | 538‡ | 800 |

*— 3 Original primary sero-negative cases were retreated.

†—10 Original primary sero-positive cases were retreated.

‡—32 Original secondary cases were retreated.

(46 Retreats on 45 patients).

TABLE II

| | Spinal Wassermann | | | | Collodial Gold Curve | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1st neg. | Recheck | 1st pos. | Recheck | 1st pos. | 1st neg. | pos. | neg. | C.N.S. | Rx. |
| SI— | 53 | 6 | ..... | ..... | 2 | 53 | ..... | 4 | ..... | ..... |
| SI+ | 200 | 31 | 2 | ..... | 33 | 199 | ..... | 32 | ..... | ..... |
| SII | 456 | 66 | 27 | 5 | 32 | 452 | 8 | 63 | 4 | 4 Malaria |
| | 707 | 103 | 29 | 5 | 67 | 704 | 8 | 99 | 4 | |

Five patients had both pre- and immediate post-treatment spinals, not because of reactions.

We have not used the eight-day drip method in this series, feeling that with it 240 mg. the first day and 120 mg. for the seven succeeding days could not be so routinely followed, because in our experience, due to primary fever, nausea, emesis, and Herxheimer, a greater number were discontinued without completing the total scheduled first day's amount, which was prorated over the succeeding days. Age, sex, color, marital status, and stage of disease is given in Table I.

**Spinal Fluids:**

Routine spinal fluid examination was made on all except pregnant cases, which were done following delivery, on the advice of the Obstetrical Department. No apparent difference in treatment course was noted in approximately the first three hundred routine spinals, one-half of which were done pre-treatment and one-half post-treatment. Recheck spinal fluid examinations are scheduled at six to twelve months post-treatment. A resume of spinal fluid findings are recorded in Table II.

Pre-treatment routine spinals and rechecks six to twelve months post-treatment, as in penicillin syphilis study, are scheduled now.

**Darkfield Examination:**

Positive darkfield examinations were found in 298 patients.

**Retreats:**

We have not retreated cases in which there was a temporary upsurge in serology, but have more closely observed them for continued increasing titre and until the appearance of objective clinical manifestations. Our incidence of infectious relapse with regard to the stage of syphilis is shown in retreatment and results tables V and VI.

**Pregnancy:**

Expectant mothers tolerate treatment well, but extra caution and close observation must be exercised because of the additional load and the associated toxemia of pregnancy. We feel that massive arseno-therapy is still to be considered seriously and used cautiously; however, the outcome has been most satisfactory, and bids fair to offer the highest hope and best prognosis for babies of syphilitic mothers in the active stage of their infection. We have treated eighty-seven patients who were pregnant at the time, or who later became pregnant.[5] Their diagnosis, time of treatment in relation to pregnancy, and dosage given are as follows:

| | Primary Sero-Negative | Primary Sero-Positive | Secondary | Total |
|---|---|---|---|---|
| 1200 mg. arsenoxide only | 1 | 4 | 7 | 22 |
| 1200 mg. arsenoxide plus bismuth | 1 | 2 | 38 | 41 |
| 1200 mg. x 2 arsenoxide plus bismuth | ..... | ..... | 4 | 4 |
| 1200 mg. x 3 arsenoxide plus bismuth[5] | ..... | ..... | 1 | 1 |
| —1200 mgs. arsenoxide only | ..... | ..... | ..... | ..... |
| —1200 mg. arsenoxide plus bismuth | 1 | 2 | 16 | 19 |
| | | | | 87 |

[5] Bowman, George W., and Huber, Carl: Massive Arseno-therapy of Syphilis and Pregnancy, *Bull. Ind. St. Bd. Health*, XLVI: 86, No. 4, (April) 1943.

TABLE III

MOTHERS — STATUS AT AND NUMBER OF MONTHS POST-TREATMENT TO DELIVERY

| | | 1-3 | 4-6 | 7-12 | 13-18 | 19-24 | 25-30 | 31-36 | 37-42 | 43-48 | 49+ | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GOOD | SI— | | | 1 | | 1 | 1 | | | | | 3 |
| | SI+ | 1 | 1 | 1 | 2 | 1 | | | | | | 6 |
| | SII | 1 | 2 | 9 | 7 | 5 | 1 | 1 | 3 | | | 29 |
| SATIS-FACTORY | SI— | | | | | | | | | | | |
| | SI+ | | 2 | | | | | | | | | 2 |
| | SII | 11 | 6 | 4 | 2 | | | 1 | | | | 24 |
| NO SERO CHANGE | SI— | | | | | | | | | | | |
| | SI+ | | | | | | | | | | | |
| | SII | 9 | 2 | 1 | 1 | | | | | | | 13 |
| Total | | | | | | | | | | | | 77 |

| | Primary Sero-Negative | Primary Sero-Positive | Sec-ond-ary | Total |
|---|---|---|---|---|
| Treated before pregnancy | 3 | 5 | 34 | 42 |
| Treated during first trimester | | 1 | 6 | 7 |
| Treated during second trimester | | 1 | 20 | 21 |
| Treated during third trimester | | 1 | 16 | 17 |
| | | | | 87 |
| Delivered | 3 | 7 | 67 | 77 |
| Not yet delivered | | 1 | 9 | 10 |
| Unknown | | | 1 | 1 |
| | | | | 87 |

The clinical and sero status of mothers at delivery and at analyzed observation period, and also of their babies is given in Tables III and IV.

Five pregnant patients received seven retreatments. Infectious relapse was found in three, and reinfection in four, and another reinfection was not retreated by second five-day drip, but by standard syringe method.

There are six living second babies, delivered of five-day-treated mothers with no further interim treatment.

Two patients, undelivered, are now with third pregnancies—no further treatment.

Of the delivered pregnancies, there are 67 living, of whom 3 are positive and 64 are negative; 9 dead, of whom 4 were positive and 3 negative, 1 stillborn, and 1 miscarriage at three months.

67 Living
9 Dead
1 Unknown
—
77 Delivered pregnancies
10 Undelivered
—
87 Treated pregnancies

Three more mothers have delivered, and five more pregnant, undelivered patients have been treated. None of these are included in our figures.

**BABIES**

**At Birth**

| | | Clinically | |
|---|---|---|---|
| Sero-positive | 14 | | |
| Doubtful | 14 | Positive | 6 |
| Sero-negative | 47 | Negative | 69 |
| Unknown | 2 | Unknown | 2 |
| Total | 77 | Total | 77 |

**At Present**

| | | Clinically | |
|---|---|---|---|
| Sero-positive | 3 | Positive | 3 |
| Sero-negative | 64 | Negative | 64 |
| Unknown | 1 | Unknown | 1 |
| | | Died | 9 |
| Total | 68 | Total | 77 |

**Infant Deaths were:**

1. A three-month miscarriage following a fall, was the second pregnancy of mother after five-day treatment. The first pregnancy delivered at term, and both baby (thirty-one months old) and mother twenty-eight months after five-day are clinically- and sero-negative sustained (non-syphilitic).

2. Term delivery, mother and baby both clinically- and sero-negative, died at two days, fall previous week, (non-syphilitic).

3. A stillbirth in a distant city, no data available, ten months post five-day.

4. A term baby, one hour after delivery, florid secondary mother treated at eighth month. Congenital, bilateral, talotibial abnormality; bilateral atelectasis; internal hemorrhage; and positive serology (syphilitic).

5. A full-term baby, of secondary mother treated at mid-term, died at three months of malnutrition, diarrhea, osteochondritis, positive serology (syphilitic).

6. A full-term baby died at three months of an undetermined etiology—dermatitis factitia (all tissues were negative to arsenic determination tests). All serology tests for syphilis were negative.

7. A full-term baby of mother treated at third month died at three months, clinically- and sero-negative, of pneumonia.

8. A term baby died of pneumonia at two months, clinically- and sero-negative at birth and at death (non-syphilitic).

9. A stillbirth whose mother was treated before pregnancy and was clinically- and sero-negative; cause unknown—distant city.

The diagnosis of a baby born with clinical syphilis is not difficult, but the status of an apparently normal baby born to a known syphilitic mother requires care, skill, patience, and time to prove. Diagnosis

**TABLE IV**

**MOTHERS PRESENT STATUS AND MONTHS POST-TREATMENT (Delivered and not yet delivered)**

| | | 1-3 | 4-6 | 7-12 | 13-18 | 19-24 | 25-30 | 31-36 | 37-42 | 43-48 | 49 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GOOD | SI— | | | | 1 | 1 | | | 2 | | | 4 |
| | SI+ | 1 | | | 1 | 1 | 1 | | 3 | | | 7 |
| | SII | | | 1 | 5 | 9 | 9 | 5 | 8 | 4 | 1 | 42 |
| SATIS-FACTORY | SI— | | | | | | | | | | | |
| | SI+ | | | | | | | | | | | |
| | SII | 5 | | 3 | 4 | 4 | 3 | 2 | 1 | 2 | | 24 |
| NO SERO CHANGE | SI— | | | | | | | | | | | |
| | SI+ | | | | | | | | | | | |
| | SII | 1 | | 3 | 1 | 3 | | | 1 | | 1 | 10 |
| Total | | | | | | | | | | | | 87 |

should be made only on positive findings, and even with characteristic clinical symptoms should be corroborated by rechecked positive laboratory findings.

Examination of placenta and darkfields of umbilical vein-wall scrapings have been made. Routine long-bone x-rays are done on all our babies, and cord and corporeal serology at birth, and at two, four, eight, and twelve weeks of age.

**Syphilitic Babies Living Are:**

1. One whose mother was given five-day treatment April 2-6, 1942, before pregnancy, and who had sustained negativity with all serologic tests for syphilis, but was reinfected before delivery by untreated husband, and delivered a clinically- and serologically-positive infant.

2. One para II delivered of mother treated September 9-13, 1940, before first pregnancy, delivered full term and sustained negativity now forty-one months old whose mother was reinfected prior to delivery of this baby.

3. One whose mother was treated March 28-April 1, 1943, delivered December 17, 1943, after clinical- and sero-negativity and upsurge, a clinical and sero-positive baby.

Babies who were clinically-negative, sero-positive, or doubtful at birth were observed and not treated, and whose mothers had not yet attained sero-negativity were considered as carry-over of maternal "reagin." They usually become sero-negative, all tests at six to eight weeks after delivery.

Color, sex, and age of living babies follow:

White 39, colored 38, total 77. Male 34, female 40, 1 unknown, 1 lost, 1 miscarriage, total 77.

The number of babies at the different age breakdowns are—ages in months:

| *1-3 mos.* | *4-6 mos.* | *7-9 mos.* | *10-12 mos.* | *13-15 mos.* | *16-18 mos.* |
|---|---|---|---|---|---|
| 4 | 4 | 12 | 3 | 8 | 7 |
| *19-24 mos.* | *25-30 mos.* | *31-36 mos.* | *37-42 mos.* | *43-48 mos.* | *Total* |
| 6 | 10 | 7 | 4 | 2 | 67 |

Observations from a serological viewpoint made previously have been substantiated on subsequent analyses as our series has grown, namely:

1. The insufficiency of employing a single test of moderate sensitivity in sero-diagnosis.

2. The inadequacy of quantitative procedures only as a treatment guide.

3. The doubtful value of the initial titre in prognosis.

4. The questionable value of rises in titre (unless continued increasing upsurge and finally corroborated clinically).

The abbreviations used throughout are: S.T.S. for Serologic Test for Syphilis; W. for Wassermann; Kl. for Kline; M. or Maz. for Mazzini; KS. for Kahn Standard; and KQ. for Kahn Quantitative Test.

**REINFECTION**[6]

A. Previous infection, orthodox standard treatment (not five-day) and cure, and new infection:

*Case No. 74.*

E.W., original infection in April, 1936, primary; darkfield positive; sero-positive; site of lesion, penis, coronal sulcus. Received 27 injections of neoarsphenamine, total 9.96 grams; 36 injections of bismuth subsalicylate, total 3.76 grams; and 22 mercury inunctions. Clinically negative with serology completely negative since June, 1936. Spinal fluid negative throughout. This resumé taken from United States Navy syphilis register, submitted by Surgeon General, U.S.N., January, 1941. Genital lesion of glans, primary; sero-positive; coexistent acute G.C., one month's duration. Positive contact source placed under treatment. Received 1200 mg. of mapharsen January 13-17, 1941. Spinal fluid negative at end of treatment. Clinically negative and diminishing titre STS at four months. W. 3+; Kl. 3+; Maz. 4+; KS. +; KQ. 1 unit.

*Case No. 137.*

M.G., original infection in 1933, secondary, generalized eruption March 13, 1933. W. 4+; Kl. 4+; Maz. 4+; and KS. 4+. Received 35 injections of neoarsphenamine, 54 bismuth subsalicylate, and 22 tryparsamide from March 20, 1933, to August 16, 1937. Blood serology February 19, 1933: 0,0,0,0. Spinal fluid August 20, 1934: W. O.; globulin 2+; cells 8; gold curve 0033330000 before tryparsamide. Negative clinically and serologically up to present time. Positive source under treatment.

July 16, 1941—Patient presented with a single indurated lesion, right labia majora (original on opposite side); darkfield positive; sero-positive; W. 4+; Kl. 4+; Maz. 4+; KS. 4+; and KQ. 80 units. Spinal fluid negative throughout; gold curve 0000000000. Received 1200 mg. mapharsen July 21-26, 1941. Progressive serologic decline; clinically negative. Spinal fluid negative at six, twelve, and eighteen months, and blood serology at one and three years. W. 0; Kl. 0; Maz. 0; KS. 0; and KQ. 0.

B. Post-original infection five-day treated, cured, and new infection:

*Case No. 62.*

E.J.G., secondary, generalized eruption; healed vulval primary lesion; sore throat, mucuous patches in throat; moist condylomata, labial; darkfield positive; W. 3+; Kl. 4+; Maz. 4+; KS. 4+; and KQ. 40 units. Received 1200 mg. of mapharsen August 26-30, 1940. Clinically negative, declining serology to complete negative serology from February, 1941, to December, 1941. Spinal and gold curve negative.

*Readmitted as Case No. 201.*

New genital primary lesion, darkfield positive, sero-positive, 4,4,4,4,40. Received 1200 mg. of mapharsen December 27-31, 1941. Spinal and gold curve negative. Declining serology to five months 0,1,1,0,0; six months 4,4,4,4,40.

*Readmitted again as Case No. 338.*

Infectious clinico-serologic relapse September, 1942, retreated 1200 mg. of mapharsen September 1-5, 1942, and bismuth cevitamate 100 mg. Was then pregnant. Delivered negative baby, and patient now twenty-eight months post-treatment; satisfactory serology, clinically negative; W. 0; Kl. 1+; Maz. 3+; KS, 0; and KQ. 0. Spinal negative.

*Case No. 207.*

T.Mc., original primary genital lesion; darkfield positive, sero-negative; W. 0; Kl. 0; Maz. 0; KS. 0; and

[6] Schoch, Arthur, and Alexander, Jo C.: Re-infection in Syphilis, *Am. J. Syph., Gonor., and Ven. Dis.*, **27**:15-29, No. 1, (Jan.) 1943.

KQ. 0. Received 1200 mg. of mapharsen January 3-9, 1942. Clinically- and sero-negative until new lesion, definite exposure, new site different from original lesion; darkfield positive, and partially sero-positive. Spinal fluid and gold curve negative.

*Readmitted as Case No. 317.*

Received 1200 mg. of mapharsen and 180 mg. of bismuth cevitamate July 30-August 3, 1942, as new infection. At present thirty months post-treatment, W. 0; Kl. 0; Maz. 0; KS. 0; and KQ. 0. Spinal fluid and gold curve negative.

*Case No. 29.*

M.M., original secondary. Received 1200 mg. of mapharsen October 21-25, 1940. At one and one-half years, W. 0; Kl. 0; Maz. 0; KS. 0; and KQ. 0. Spinal fluid and gold curve negative.

*Readmitted as Case No. 318.*

In July, 1942, anal primary lesion; darkfield positive; sero-positive; W. 4+; Kl. 4+; Maz. 4+; KS. 4+; and KQ. 4 units. Positive source, sodomist, under treatment. Received 1200 mg. of mapharsen and 160 mg. of bismuth cevitamate. At thirty months post-treatment, declining serology but clinically negative, W. 2+; Kl. 3+; Maz. 4+; KS. 4+; and KQ. 40. Spinal negative gold curve 0000000000, at Army induction July 2, 1943.

*Case No. 242.*

J.F., primary genital lesion; darkfield positive; sero-positive, W. 1+; Kl. 3+; Maz. 3+; KS. 3+; and KQ. 3 units. Received 1200 mg. of mapharsen March 16-20, 1942. At four months post-treatment, W. 0; Kl. 0; Maz. 0; KS. 0; KQ. +, and clinically negative. Also received 304 mg. of thio-bismol while hospitalized. Eight months later (November, 1942) reported as spinal- and gold-curve negative.

*Readmitted as Case No. 375.*

Healed, new genital lesion, secondary, florid; positive source under treatment. W. 2+; Kl. 4+; Maz. 4+; KS. 4+; and KQ. 40 units. Received 1200 mg. of mapharsen, and 120 mg. of bismuth cevitamate November 9-14, 1942. At twenty-six months clinically- and sero-negative, W. 0; Kl. 0; Maz. 0; and KS. 0. Spinal and gold curve negative.

*Case No. 325.*

A.R., original secondary, generalized maculopapular eruption. W. 4+; Kl. 3+; Maz. 4+; KS. 4+; KQ. 120 units. Received 1200 mg. of mapharsen and 140 mg. of bismuth cevitamate July 29-August 2, 1942. Clinically negative with declining serology, W. 0; Kl. 4+; Maz. 4+; KS. —; and KQ. 0. Spinal fluid negative.

*Readmitted as Case No. 392.*

December, 1942, new coronal herpetiform lesion; darkfield positive, increasing serology. W. 2+; Kl. 4+; Maz. 4+; KS. 3+; and KQ. 3 units. Received 1200 mg. of mapharsen, and 301 mg. of thio-bismol, December 7-11, 1942. Clinically and serologically negative at present; W. 0; Kl. 0; Maz. 0; KS. 0; KQ. 0; and twenty-five months post-retreatment spinal negative.

*Case No. 285.*

A.R., primary genital lesion; darkfield, positive; sero-negative; W. 0; Kl. 0; Maz. 0; KS. 0; and KQ. 0. Received 1200 mg. of mapharsen, and 90 mg. of bismuth cevitamate June 2-6, 1942. Lost at one month. Serology at that time: W., Kl., M., KS., KQ— all negative. Spinal negative.

*Readmitted as Case No. 387.*

November, 1942, secondary, discrete eruption, healed primary. W. 4+; Kl. 4+; M. 4+; KS. 4+; and KQ. 240 units. Received 1200 mg. of mapharsen, and bismuth cevitamate 120 mg. No change serologically, but clinically negative at two months. Good at twenty-five months; 0,0,0,0,0, all STS. Spinal negative.

*Case No. 3.*

L.J., secondary, darkfield positive; sero-positive; received 1200 mg. of mapharsen September 23-28, 1940; clinically and serologically negative for two years. Spinal negative.

*Readmitted as Case No. 467.*

History of new genital lesion a month earlier, and has generalized secondary papular-macular eruption. Known positive source. Retreated as a new infection April 26-31, 1943. Admission serology, W. 4+; Kl. 4+; M. 4+; KS. 4+; and KQ. 80 units. Received 1000 mg. of mapharsen, and 200 mg. of bismuth cevitamate. Clinically negative, declining serology.

*Case No. 355.*

L.F., original secondary; W. 4+; Kl. 4+; M. 4+; KS. 4+; KQ. 80 units. Received 1200 mg. of mapharsen, plus 100 mg. of bismuth cevitamate September 28-October 2, 1942. At six months, clinically negative; serology: W. 0; Kl. 1+; M. 2+; KS. 0; and KQ. 0. Spinal fluid negative.

*Readmitted as Case No. 473.*

New primary lesion on shaft of penis; W. 4+; Kl. 4+; M. 4+; KS. 4+; and KQ. 20 units. Received 1200 mg. of mapharsen, plus bismuth cevitamate, May 3-8, 1943. Clinically negative. Satisfactory, W. 0; Kl. 0; M. 1+; KS. 0; and KQ. 0 units twenty months. Spinal fluid negative.

*Case No. 99.*

RMc., original lip primary; darkfield positive; W. 2+; Kl. 3+; and M. 4+. Received 1200 mg. of mapharsen March 18-22, 1941. Clinically- and sero-negative in all STS. Spinal negative from third month to twenty-four months post first five-day treatment.

*Readmitted as Case No. 488.*

History of another genital lesion scar, known source with throat mucous patch, skin macular eruption, retreated as new infection. W. 4+; Kl. 4+; M. 4+; KS. 4+; and KQ. 160 units. Spinal negative. Received 1200 mg. of mapharsen June 2-7, 1943, and bismuth cevitamate. Clinically negative and satisfactory nineteen months post second five-day. W. 0; Kl. 1+; M. 2+; KS. 0; and KQ. 0.

*Case No. 81.*

M.Y., original secondary; moist condylomata, genital and anal; darkfield positive; W. 4+; Kl. 4+; M. 4+; KS. 4+; and KQ. 160 units. Received 1200 mg. of mapharsen January 20-24, 1941. Clinically- and sero-negative. W. 0; Kl. 0; M. 0; KS. 0; and KQ. 0. Spinal fluid and gold curve negative twenty months post-treatment.

*Readmitted as Case No. 479.*

History, genital lesion one month; darkfield positive; W. 4+; Kl. 4+; M. 4+; KS. 4+; and KQ. 80 units Retreated as new infection, 1000 mg. of mapharsen and 180 mg. of bismuth cevitamate. Satisfactory and clinically negative. W. 0; Kl. 1+; M. 2+; KS. 1+; and KQ. 1 unit. Spinal fluid and gold curve negative at twenty months post second treatment.

*Case No. 172.*

W.F., original primary; darkfield positive; sero-positive. Received 1200 mg. of mapharsen October 31-November 4, 1941. At third month post-treatment clinically negative; declining serology, W. 0; Kl. 4+; M. 4+; KS. 3+; and KQ. 3 units. Spinal fluid and gold curve negative with history of no lesions in interim and a known positive contact source.

*Case No. 528.*

Primary penile lesion; darkfield positive; W. 1+; Kl. 4+; M. 4+; KS. 4+; and KQ. 40 units. Received 1122 mg. of mapharsen and 448 mg. of bismuth subsalicylate almost two years after first five-day, or from August 13-17, 1943. Clinically negative, spinal fluid negative, and serology, W. 1+; Kl. 4+; M. 4+; KS. 4+; and KQ. 16 units, and lost.

*Case No. 255.*

B.W., original secondary; generalized eruption; throat and genital mucuous patches; darkfield positive; W. 4+; Kl. 4+; M. 4+; KS. 4+; and KQ. 160 units. Received 1200 mg. of mapharsen April 10-14, 1942. Progressed to six months clinically negative. W., Kl., M., KS., KQ., spinal and gold curves, all negative. Husband has been on irregular inadequate out-patient treatment only. Patient pregnant. Delivered outside and readmitted as probable reinfection from husband with a congenitally syphilitic baby.

*Readmitted as Case No. 530.*

W. 4+; Kl. 4+; M. 4+; KS. 4+; KQ. 80 units, and negative spinal and gold curve. Received 1200 mg. of mapharsen and 336 mg. of bismuth subsalicylate August 23-26, 1943. Is clinically negative, satisfactory at seventeen months. W. 0; Kl. 0; M. 1+; KS. 0; and KQ. 0 units. Opinion: reinfected from husband during pregnancy. Husband requested and received five-day treatment following inadequate standard test and syphilitic baby.

*Case No. 354.*

E.W., original secondary; generalized eruption, genital moist lesions; W., Kl., M., KS., all 4+; KQ. 240 units. Received 1200 mg. of mapharsen September 28-October 2, 1942. Clinically negative, declining serology at five months, W. 4+; Kl. 2+; M. 4+; KS. 4+; and KQ. 4 units. Spinal and gold curve negative. Returned and retreated as a possible reinfection.

*Readmitted as Case No. 507.*

W. 4+; Kl. 4+; M. 4+; KS. 4+; and KQ. 80 units. Spinal negative, darkfield positive, and generalized skin eruption. Received 1000 mg. of mapharsen and 336 mg. of bismuth subsalicylate July 20-24, 1943. Is clinically negative, no change in serology except decreased quantitative at eighteen months post-treatment. W. 0; Kl. 1+; M. 2+; KS. 0; and KQ. 0 units.

*Case No. 482.*

D.De., secondary; generalized eruption, healed genital. Received 1000 mg. of mapharsen, and 180 mg. of bismuth cevitamate May 23-27, 1943. W. 0; Kl. 0; M. 1+ in January, 1944.

*Readmitted as Case No. 619.*

New darkfield positive; genital lesion, new location, on March 18-22, 1944, W. 2+; Kl. 1+; M. 2+; KS. 4+; and KQ. 160 units. Received 1200 mg. mapharsen and 336 mg. of bismuth subsalicylate. At ten months, satisfactory; is clinically negative, and serology, W. 0; Kl. 0; M. 2+; KS. 0; and KQ. 0 units.

*Case No. 50.*

L.R., secondary. Received 1200 mg. of mapharsen November 4-8, 1940. Satisfactory, clinically negative, and declining to negative serology from October, 1942. Readmitted three years later as a new infection November 19, 1943.

*Readmitted as Case No. 570.*

Healed primary, one month, and generalized macular eruption. W. 0; Kl. 4+; M. 4+; KS. 4+; and KQ. 160 units. Received only 152 mg. of mapharsen, resulting in angio-neurotic, symptom-complex reaction. No further treatment to date. Clinically negative, and W. 0; Kl. 3+; M. 4+; KS. 2+; KQ. —. Penicillin candidate.

*Case No. 417.*

E.J., secondary treated January 17-20, 1943. Received 960 mg. of mapharsen and 120 mg. of bismuth cevitamate, progressed to sustained sero-negativity from two months to twelve months when he had a new infection, known source.

*Readmitted as Case No. 580.*

Secondary, early; W., Kl., M., KS., all 4+; KQ., and 360 units. Received 1000 mg. of mapharsen and 336 mg. of bismuth subsalicylate January 8-14, 1944. Clinically negative at twelve months; serology, W. 0; Kl. 0; M. 1+; KS. 0; and KQ. 0.

*Case No. 391.*

I.H., secondary. Received 1040 mg. of marpharsen and 380 mg. of thio-bismol December 5-11, 1942. Progressed to full sustained sero-negative from fourth month to ten months.

*Readmitted as Case No. 567.*

Labial multiple new lesions, and W. 3+; Kl. 4+; M. 4+; KS. 4+; and KQ. 120 units. Retreated with 1200 mg. of mapharsen and 224 mg. of bismuth subsalicylate from November 17-21, 1943, as a primary sero-positive, with new infection, known source, and is satisfactory with declining serology at fourteen months, W. 0; Kl. 1+; M. 1+; KS. 1+; and KQ. 1.

*Case No. 184.*

I.S., second, florid; received 1185 mg. of mapharsen November 21-25, 1941. Progressed to a sustained full sero-negativity from twelve months to twenty-four months.

*Readmitted as Case No. 571.*

Genital lesion and generalized eruption; W. 4+; Kl. 3+; M. 4+; KS. 4+; and KQ. 160 units. Was retreated as new infection. Received 1100 mg. of mapharsen and 224 mg. of bismuth subsalicylate November 24-25, 1943, and December 4-6, 1943. At fourteen months clinically negative, declining serology, W. 0; Kl. 0; M. 2+; KS. 0; and K.Q. 0 units.

*Case No. 364.*

O'N.J.D., primary, sero-positive. Received 1200 mg. of mapharsen December 14-18, 1942, became sero-negative in all STS fourth month, and was lost until readmitted with a new infection

*Readmitted as Case No. 646.*

Genital lesions, generalized eruption; was treated as new infection May 2-6, 1944. W. 4+; Kl. 1+; M. 4+; KS. 4+; and KQ. 80 units. Received 1200 mg. of mapharsen and 336 mg. of bismuth subsalicylate. Clinically negative, and at eight months, W. 0; Kl. 0; M. 0; KS. 0, and KQ. 0 units.

*Case No. 252.*

H.J., secondary florid. Received 1200 mg. mapharsen and bismuth subsalicylate April 1-5, 1942. Uneventful progress to twenty-nine months post-treatment.

*Readmitted as Case No. 741.*

Healed primary, and a new generalized eruption and moist labial condylomata was retreated at thirty months following original five-day with 1200 mg. of mapharsen and 336 mg. of bismuth subsalicylate from September 15-19, 1944. Is now satisfactory; clinically negative at four months post second five-day. W. 1+; Kl. 1+; M. 2+; KS. 4+, and KQ. 10 units.

*Case No. 657.*

M.D., secondary, with generalized maculo-papular rash. W. 4+; Kl. 4+; M. 4+; KS. 4+; KQ. 40 units. Negative spinal fluid. Was treated May 27-31, 1944, and received 1200 mg. of mapharsen and 336 mg. of bismuth subsalicylate. Severe cerebral reaction with multiple convulsions third day post-treatment. Stormy convalescence, followed by rapid serologic decline to negativity, all STS. from July 3, 1944, to September, 1944, when all STS. became positive and with increasing titre and a new labial (left) lesion with fibrosis, followed two weeks later by generalized pigmented papular eruption. Coexistent profuse gonorrhea. Diagnosed as a new infection. Because of reaction post original five-day was given 2,400,000 oxford units of penicillin (20,000 u q 3 h) from December 31, 1944, to January 14, 1945. Spinal fluid negative pre-Rx. Clinically negative, and at present serology is negative, all tests.

## TABLE V

### RETREATED PATIENTS

### INFECTIOUS (CLINICO-SERO) RELAPSES, REINFECTIONS AND STATIC SEROLOGY

| | Case No. | Original Treotment Date | Infectious Relapse or *Reinfection Interval | Time Retreoted | Date Retreated | Post-Treotment Present Time (Months) | Present Status | Present Serology W, Kl, M, KS, KQ. |
|---|---|---|---|---|---|---|---|---|
| PRIMARY Sero-Negative | 27/89 (?*) | 11/25-29/40 | 3 mos. | 3 mos. | 2/24-28/41 | 47 | Good | 0, 0, 0, 0, 0 |
| | 285/387* | 6/2-6/42 | 7 mos. | 7 mos. | 12/1-5/42 | 25 | Good | 0, 0, 0, 0, 0 USA |
| | 207/317* | 1/3-9/42 | 6+ mos. | 7 mos. | 7/30-8/3/42 | 30 | Good | 0, 0, 0, 0, 0 USA |
| PRIMARY Sero-Positive | 8/77 | 7/24-29/40 | 3-4 mos. | 6 mos. | 1/7-11/41 | | Died 3½ years post-Rx. of pneumonia | |
| | 24/88 | 9/30-10/4/40 | 3-4 mos. | 6 mos. | 2/4-8/41 | 45 | Unknown | Lost at 12 mos. |
| | 125/191 | 7/1-5/41 | 3-4 mos. | 5 mos. | 11/27-12/1/41 | 37 | Satisfactory | 0, 0, 1, 2 |
| | 201/338 | 12/27-31/41 | 3-4 mos. | 4 mos. | 9/1-5/42 | 28 | Satisfactory | 0, 1, 3, 0, 0 |
| | 29/318* | 10/21-25/40 | 18 mos. | 18 mos. | 7/30-8/3/42 | 30 | Satisfactory | 2, 3, 4, 4, 40 USA |
| | 83/152 | 1/28-2/1/41 | Static | 8 mos. | 8/25-29/41 | 41 | Good | 0, 0, 0, 0, 0 USA |
| | 242/375* | 3/16-20/42 | 6 mos. | —8 mos. | 11/9-13/42 | 26 | Good | 0, 0, 0, 0, 0 |
| | 99/488 | 3/18-22/41 | 25 mos. | 26 mos. | 6/2-6/43 | 19 | Satisfactory | 0, 1, 2, 0, 0 |
| | 364/646* | 10/14-18/42 | 18 mos. | 19 mos. | 5/2-6/44 | 8 | Good | 0, 0, 0, 0, 0 |
| | 620/688 | 3/20-24/44 | 3 mos. | 4 mos. | 7/17-21/44 | 6 | Satisfactory | 4, 3, 4 |
| SECONDARY | 105/138 | 4/14-18/41 | 3 mos. | 3 mos. | 7/21-26/41 | 42 | Good | 0, 0, 0, 0, 0 |
| | 103/133 | 4/14-18/41 | 3 mos. | 3 mos. | 7/21-26/41 | 42 | Good | 0, 0, 0, 0, 0 |
| | 92/134 | 3/18-22/41 | 3 mos. | 4 mos. | 7/28-8/1/41 | 42 | Good | 0, 0, 0, 0, 0 |
| | 147/257 | 8/25-29/41 | —5 mos. | 8 mos. | 4/14-18/42 | 33 | Good | 0, 0, 0, 0, 0 |
| | 56/102 | 12/9-13/40 | 3 mos. | 4 mos. | 4/7-11/41 | 45 | Good | 0, 0, 0, 0, 0 |
| | 31/226 | 12/3-7/40 | 3 mos. | 8 mos. | 2/23-27/42 | 35 | Good | 0, 1, 2, 0, 0 |
| | 129/194 | 7/14-18/41 | 4 mos. | 4 mos. | 12/5-9/41 | 37 | Satisfactory | 1, 3, 4, 4, 16 |
| | 41/124 | 10/21-24/40 | 4 mos. | 4 mos. | 7/1-5/41 | 42 | Good | 0, 0, 0, 0, 0 |
| | 111/211 | 5/12-16/41 | 5 mos. | 8 mos. | 1/17-19/42 | 36 | Good | 0, 0, 0, 0, 0, |
| | 170/304 | 10/27-31/41 | 5-6 mos. | 8 mos. | 7/4-8/42 | 30 | No change | 4, 4, 4, 4, 20 CNS |
| | 325/392* | 7/29-8/2/41 | 5 mos. | 5 mos. | 12/7-11/42 | 25 | Good | 0, 0, 0, 0, 0 |
| | 62 SII | 8/26-30/40 | 11 mos. good | 11 mos. | | | Good | 0, 0, 0, 0, 0 |
| | 201* | | See Primary | Sero-Positive | 12/27-31/41 | | | |
| | 338 | | See Primary | Sero-Positive | 9/1-5/42 | | | |
| | 387* | | See Primary | Sero-Negative | 12/1-5/42 | | | |
| | 3/467* | 9/24-28/41 | 2+ years | 2+ years | 4/26-30/43 | 21 | Unknown | Lost 2 weeks |
| | 331/440 | 8/18-22/42 | 6 mos. | 7 mos. | 3/3-7/43 | 22 | Satisfactory | 0, 0, 2, 0, 0 |
| | 278/436 | 5/25-29/42 | Static | 9 mos. | 2/26-3/2/43 | 23 | Satisfactory | 2, 0, 1, 0, 0 |
| | 355/473* | 9/29-10/3/42 | 8 mos. | 8 mos. | 5/5-9/43 | 20 | Satisfactory | 0, 0, 1, 0, 0 |
| | 204/413 | 1/3-7/42 | Static | 1 year | 1/10-14/43 | 24 | Good | 0, 0, 0, 0, 0 USA |
| | 81/479* | 1/20-24/41 | 22 mos. | 22 mos. | 5/18-22/43 | 20 | Satisfactory | 0, 1, 2, 1, 1 |
| | 281/487 | 5/26-30/42 | 12 mos. | 12 mos. | 5/31-6/4/43 | 19 | No change | 2, 4, 4, 4, 20 |
| | 354/507*? | 9/28-10/2/42 | 10 mos. | 10+ mos. | 7/21-25/43 | 18 | Satisfactory | 1, 1, 3, 0, 0 |
| | 172/528* | 10/31-11/4/41 | 10 mos. | 10 mos. | 8/13-17/43 | 17 | No change lost | 1, 4, 4, 4, 160 |
| | 255/530* | 4/2-6/42 | 16 mos. | 16 mos. | 8/23-27/43 | 17 | Good | 0, 0, 1, 0, 0 |
| | 531/598 | 8/26-30/43 | 4-5 mos. | 6 mos. | 2/9-13/44 | 11 | Satisfactory | 0, 1, 1, 1, 1 |
| | 484/572 | 5/28-6/1/43 | 4+ mos. | 5 mos. | 11/29-12/3/43 | 13 | Satisfactory | 0, 0, 0, 0, 0 |
| | 437/630 | 2/26-3/2/43 | Unknown | 13 mos. | 4/6-10/44 | 9 | No change | 2, 3, 4, 4, 10 |
| | 417/580* | 1/17-20/43 | *1+ year | 12+ mos. | 1/8-14/44 | 12 | Good | 0, 0, 1, 0, 0 |
| | 391/567* | 12/5-11/42 | 11 mos. | 11 mos. | 11/17-21/43 | 14 | Satisfactory | 0, 1, 1, 1, 1 |
| | 184/571* | 11/21-25/41 | *24 mos. | 24 mos. | 11/24-12/6/43 | 14 | Good | 0, 0, 2, 0, 0 |
| | 482/619*? | 5/23-27/43 | *8+ mos. | 10 mos. | 3/18-22/44 | 10 | Satisfactory | 0, 0, 2, 0, 0 |
| | 50/570* | 11/4-8/40 | *24 mos. | 24+ mos. | 11/19-20/43 | 14 | | 0, 3, 4, 2 |
| | 252/741* | 4/1-5/42 | *29 mos. | 30 mos. | 9/15-19/44 | 4+ | Satisfactory | 0, 2, 3, 2 |
| | 617/661 | 3/15-19/44 | 2 mos. | 3 mos. | 6/8-12/44 | 7 | Satisfactory | 0, 1, 1, 0, 0 |

* Case No. 29. Original secondary, retreated as a new infection, primary sero-positive No. 318.
Case No. 242. Original sero-positive, retreated as a new in ection, secondary No. 375.
Case No. 325. Original secondary, retreated as possible new infection No. 392 (or infectious relapse).
Case No. 3. Original secondary, retreated as new infection, secondary No. 467.
Case No. 354. Original secondary, retreated as new infection, secondary No. 507.
Case No. 172. Original secondary, retreated as new infection, primary sero-positive No. 528.
Case No. 255. Original secondary, retreated as new infection, secondary latent No. 530.
Case No. 81. Original secondary, retreated as new infection, secondary No. 479.
Case No. 281. Original secondary, retreated as infectious relapse No. 487.
Case No. 99. Original primary sero-positive, retreated as new infection, primary, sero-positive No. 488.
Case No. 355. Original secondary, retreated as new infection, primary sero-positive No. 473.
Case No. 207. Original primary sero-negative, retreated as a new infection, primary sero-positive No. 317.
Case No. 285. Original primary sero-negative, retreated as new infection, secondary No. 387.
Case No. 62. Original secondary, retreated as new infection, primary sero-positive No. 201, and third five-day treatment as infectious relapse No. 338.
Case No. 27. Original primary sero-negative, retreated as a primary sero-positive No. 89, new infection.
Case No. 437. Original secondary, retreated as probable reinfection early secondary No. 630.
Case No. 417. Original secondary, retreated as new infection No. 580.
Case No. 391. Original secondary, retreated as probable new infection No. 567.
Case No. 184. Original secondary, retreated as new infection No. 571.
Case No. 482. Original secondary, retreated as probable new infection No. 619.
Case No. 50. Original secondary, retreated as new infection, early secondary No. 570.
Case No. 364. Original secondary, retreated as new infection, primary sero-positive No. 646.
Case No. 620. Original primary sero-positive, retreated as an infectious relapse, sero-positive primary, darkfield positive No. 688.
Case No. 252. Original secondary, retreated as new infection, secondary No. 741.
Case No. 617. Original secondary, retreated as superimposed infection, primary sero-positive, darkfield positive No. 661.

Table V includes all retreated cases, whether clinico-infectious relapse, new infection, or other reason. Original and retreatment times are given.

**X-Rays:**

Flat-chest plates have been made routinely as a part of the general physical examination on all candidates for massive drip therapy for infectious syphilis. We were taught and are in complete accord with the accepted opinion that too intensive antisyphilitic treatment in a concomitant tuberculosis may be dangerous. "The well-recognized possibility that a syphilitic infection superimposed on a latent tuberculosis may cause a flare-up of the latter must always be borne in mind."[7,8] Moore also mentions a number of factors from a public health viewpoint which must be considered as to choice of treatment, namely: early infectious syphilis with arrested inactive tuberculosis, probable or likely promiscuity of patient with both diseases, average or better physical stamina, and more or less likelihood of local residency affording follow-up and observation. Recently, Hoffman and Adams,[9] in a much excerpted and requoted article, stated that antisyphilitic therapy must be employed regardless of the outcome of the tuberculosis, in pregnancy, and during the infectious stages of syphilis. We reported one such case,[10] latent arrested tuberculosis with early florid secondary syphilis, uneventful treatment period, who developed a type T lobar pneumonia five weeks after his intensive syphilotherapy, and flared into a galloping tuberculosis. His syphilis progress was excellent, and he had a sustained complete sero-negativity at four and one-half years post five-day treatment, and died of tuberculosis. One other early infectious secondary syphilis with negative chest plate pre-treatment developed activity of her undiagnosed latent tuberculosis one and one-half years post treatment, and with clinical and sero satisfactory syphilis progress.

**Reactions:**

Headache, nausea, and emesis during the initial day's treatment is not unusual, and about fifty per cent have had some elevation of temperature or a primary fever, accentuation of an outcoming or an already-present secondary eruption and Herxheimer reaction. The maximum temperature of this primary Herxheimer fever seen was 104.4°. Secondary fever near completion or post treatment was seen in about ten per cent of the cases. Maximum fever, secondary type, was 106.6°, and longest duration of secondary fever was ten days. We have had forty-two toxicodermas, post-treatment in character, which were moderate in character and transitory (of one to maximum three days).

Too often in the past ambulatory-treated cases have not been observed closely enough, or reactions or post-treatment sequelae have not been reported to the attending physician or clinic, and so their true incidence has been unknown and consequently only is estimated, and no doubt too low, while massive-treated hospitalized patients have been intimately studied and untoward reactions are known. This has been voiced as one of the greatest disadvantages of massive therapy.

Cumulative evidence in our experience has confirmed our opinion that different lots of arsenicals vary greatly in their toxicity, (as well as spirochetical effect) although chemical reassay may reveal no difference. Technique and apparatus must be investigated. The greater toxicity in patients undergoing reactions with fatality, and those with recovery and good clinical and serologic results, and again the toxicity in other patients who clinically relapsed at usual time expectancy, and who received other lot numbers of arsenicals, has presented patterns of recurrence of lot numbers far too frequent to be only accidental.

Acute encephalopathy, severe in character, with recovery, occurred in one male (reported)[11, 12] and two female patients. All were in active secondary stage, all occurred post-treatment at two to three days, and one occurred on the sixth day. All progressed to good clinical and serological results. We have had several other borderline cases, perhaps mild encephalopathies, with uneventful outcome.

Two patients developed marked jaundice, both treated with suspicious lot numbers. Very delayed jaundice or even a suggestion of tinting of sclerae in absence of other clinical manifestations would have been missed had the patient been released from the hospital, and if routine serum bilirubin and urobilinogen tests had not been made.

We have had one reaction of the "angio-neurotic, symptom-complex type." This was a circulatory collapse and anuria in a young negress previously treated by the five-day, slow drip method in November, 1940, for her active secondary syphilis, who progressed to negativity, and was reinfected in November, 1943, with a new healed primary lesion, known source, and in clinical secondary syphilis. She received only 153 mg. of arsenoxide (mapharsen) by drip on first day of second treatment. The valuable cooperation of the staff of the Lilly Research Foundation, Drs. Irvine Page, Robert D. Taylor, and Kenneth Kohlstaedt, and the use of angiotonin saved this patient. They have reported

[7] Stokes, John: *Modern Clinical Syphilology*, Chap. XIII, p. 286.

[8] Moore, Joseph Earl: *Modern Treatment of Syphilis*, Chap. XIV, pp. 244, 245.

[9] Hoffman, Reuben, and Adams, George G.: Syphilis and Pulmonary Tuberculosis in the Negro, *Am. Rev. Tuberc.*, **50**, No. 85, 1944.

[10] Bowman, George W., and Sheehan, Francis G.: Pulmonary Involvement in Two Cases of Early Syphilis Treated by Massive Five-Day Drip Method, *Urol. and Cutan. Rev.*, *XLVII* 635-638, No. 11.

[11] Boyd, David A., and Nie, Louis W.: Encephalopathy following Intravenous Administration of Arsenical Preparations, *Arch. Neurol. and Psychiat.*, **49**:863-877, (June) 1943.

[12] Bowman, George W., and Sheehan, Francis G.: Encephalopathy following Massive Arseno-therapy, *J.I.S.M.A.*, **37**:66-68, No. 2 (Feb.) 1944.

another similar arsenic poisoning case, with hypotension, of suicidal origin.[13]

**Deaths:**

Cerebral reaction and clinical encephalopathy was seen in three patients, two males (1 white, 1 colored) and one (white) female, all occurring the second to the third day following completion of massive treatment. Another white female with florid secondary died on the second day of treatment. She was a chronic alcoholic, and necropsy disclosed chronic liver and kidney pathology, degenerative liver changes, marked jaundice, and a cloudy swelling of the kidneys. This patient was the only one who showed petechiae throughout viscera. The cause of her death was considered as hepatic, aggravated by her arsenotherapy, although visceral analyses for arsenic concentration were inconclusive. Acute splenitis (and enlargement) was found in three of the four cases. Arsenic concentration analyses of viscerae were made for us by Drs. Robert A. Kehoe and William F. Ashe, of the Kettering Laboratory of Applied Physiology, at the University of Cincinnati. Congestion of the leptomeninges and moderate edema of brain, and edema and congestion of lungs were reported in all four cases. Early pneumonia, possibly terminal, was reported. Petechial hemorrhages in epicardium and endocardium were found. Neither of the two females were menstruating during treatment. This had previously been advanced as a contributory, predisposing factor. The tourniquet test, Rumpel-Leede, recommended as an indication of patients to hemorrhagic diathesis has not been of material value in our hands. No classical hemorrhagic encephalitis, as seen with standard neoarsphenamine or sulfarsphenamine, was seen, but was more of a so-called "wet brain" type, not grossly evident.

**Method of Analysis:**

The method of analysis used in the consolidated group study[4] was as follows:

"Cases followed for any period of time were first divided into two groups, those reaching what might be considered a 'final outcome,' and those whose status when last seen could not be determined. Four broad groups were defined as final outcomes, as follows:

1. A case negative for at least three months when last seen was considered to have experienced a satisfactory result.
2. A case still positive or fluctuating when last seen a year or more after treatment was considered 'serologically fast.' (A fluctuating case was defined to be one in which the serologic test on the blood had been negative at some time after treatment, but never for as long as three consecutive months, and had subsequently become positive. The last observation might be either positive or negative.)
3. A case positive or fluctuating at last observation which had previously fulfilled the criteria for satisfactory result was considered as a 'serologic relapse.'
4. A case experiencing relapsing secondary syphilis was considered to be a 'clinical relapse.' In so far as possible reinfections were excluded from this last category by means of the following criteria:
   (a) Completion of the prescribed course of treatment.
   (b) Blood negative to all serologic tests on two consecutive observations at least one month apart following completion of treatment.
   (c) A new lesion, not typical of recurrence, appearing prior to a serologic relapse.

"On the basis of the serologic status at given observation periods after the treatment of those cases in which a final result was noted, the probable final outcome of lapsing patients was calculated. For example, the cases in each final outcome were tabulated by serologic status one month after treatment. Then those cases that were last seen in the first month after treatment were tabulated by status at last observation. In each serologic status of the known cases the proportion of satisfactory results, serologically-fast cases, serologic relapses, and clinical relapses, was calculated. These proportions were applied to the unknown cases to find their probable results. This was done for all observation periods in which cases were seen for the last time without known final outcome.

"The percentages presented were computed from the combined known and estimated outcome. However, in applying tests of significance, the number of cases with known outcome was used as a basis."

The results given by the United States Public Health Service Evaluation on approximately seven hundred cases in our series, in October, 1944, were:

| *(Estimated percentage)* | *Satisfactory* | *Serologically fast* | *Serological Relapse* | *Clinical Relapse* |
|---|---|---|---|---|
| Sero-negative, primary.. | 86.0% | ..... | 8.0 | 6.0 |
| Sero-positive, primary.... | 85.1 | 7.1 | 3.9 | 3.9 |
| Secondary ..... | 70.4 | 17.3 | 2.6 | 9.7 |

We have used the term "good" in our analysis of results as meaning clinically and serologically negative to all tests, Wassermann, Kline, Mazzini, Kahn Standard, and Kahn Quantitative, and is equivalent to the term "satisfactory" in group study reports. Our "satisfactory" is interpreted as clinically negative, declining serology, but not all STS (serological tests for syphilis) completely negative. Usually the test of our co-worker, Mazzini, becomes positive earlier and remains positive later than the others. Quantitative Mazzini tests are now

[13] Page, Irvine H.; Taylor, Robert; and Kohlstaedt, Kenneth: A Case of Extreme Hypotension following Acute Arsenic Poisoning with Adequate Blood Supply to the Tissues, *Am.J.M.Sc.*, **205**:730-734, No. 6, (May) 1943.

**TREATMENT RESULTS—PRESENT STATUS CASES NO. 1 TO 800**

| | *Good* | *Satisfactory* | *Total* | *Sero-fast* | *Infectious Relapse* | *Re-infection* | *Retreat* | *Died* |
|---|---|---|---|---|---|---|---|---|
| Primary Sero-negative | 96.43% | ..... | ..... | 1.785% | (?1.785% | 3.59% | 5.37% | 1.785% |
| Primary Sero-positive | 58.74% | 25.243% | 83.98% | 15.532% | (?2.42% | 1.46% | 5.33% | .485% |
| Secondary | 46.435% | 31.635% | 78.07% | 21.460% | (?2.6% | 2.97% | 5.94% | .37% |

being used, but were not used routinely throughout this entire series. See Table VI.

The rate of mortality in eight hundred cases presented was 0.5 per cent. The grouping of the above "good and satisfactory" percentages by us seems justifiable because of the use of "satisfactory," based on Kahn serology by a consolidated study report, whereas our own analysis would place such cases as we have listed as only "satisfactory" and not completely sero-negative to all tests. A comparison of our own and the Public Health Service results is thus shown.

**Recapitulation:**

| | *Primary Sero-negative* | *Primary Sero-positive* | *Secondary* |
|---|---|---|---|
| Good | 54 | 121 | 251 |
| Satisfactory | --- | 52 | 171 |
| No serological change | 1 | 32 | 116 |
| Died | 1 | 1 | 2 |
| Total number of cases | 56 | 206 | 538 |

Of the above number retreated, each diagnosis was made because of

| | | | |
|---|---|---|---|
| Static serology | --- | 2 | --- |
| Infectious relapse | 1? | 5 (1?) | 14 |
| Reinfection | 2 | 3 (1?) | 18 |
| | 3 | 10 | 32 |

**Conclusion:**

The use of the slow, five-day drip method, with little or no deviation, except the addition of heavy metal and weight-dosage ratio for more than five years, and the results attained in the high percentage of cases followed for so long a period leads us to feel that there is a definite place for this method of treatment, especially in early infectious patients, thus accomplishing quarantine and adequate treatment simultaneously. At present, of any accepted treatment regime or method this offers the best results over a time-proved observation period.

**TABLE VI**

**PRESENT STATUS—800 PATIENTS—TIME IN MONTHS POST-TREATMENT**

| | *1-3 mos.* | *4-6 mos.* | *7-12 mos.* | *13-18 mos.* | *19-24 mos.* | *25-30 mos.* | *31-36 mos.* | *37-42 mos.* | *43-48 mos.* | *49-54 mos.* | *Totals* | | | *Original* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Good | 16 | 9 | 10 | 3 | 1 | 6 | 4 | 3 | ..... | 2 | 54 | ..... | ..... | SI— |
| | 14 | 23 | 18 | 11 | 8 | 19 | 14 | 12 | 1 | 1 | ..... | 121 | ..... | SI+ |
| | 9 | 25 | 44 | 30 | 37 | 28 | 22 | 24 | 12 | 20 | ..... | ..... | 251 | SII |
| Satisfactory | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | SI— |
| | 31 | 6 | 3 | 3 | 3 | 3 | 3 | 2 | 1 | ..... | ..... | 52 | ..... | SI+ |
| | 81 | 34 | 25 | 14 | 10 | 5 | 1 | 1 | ..... | ..... | ..... | ..... | 171 | SII |
| No serological Change | 1 | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | 1 | ..... | ..... | SI— |
| | 27 | 2 | ..... | ..... | 1 | ..... | 1 | 1 | ..... | ..... | ..... | 32 | ..... | SI+ |
| | 62 | 18 | 16 | 6 | 5 | 4 | 3 | 2 | ..... | ..... | ..... | ..... | 116 | SII |
| Died | 1 | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | 1 | ..... | ..... | SI— |
| | 1 | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | 1 | ..... | SI+ |
| | 2 | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | 2 | SII |
| Clinico-Infectious Relapse | 1 | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | SI— |
| | 4 | 1 | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | SI+ |
| | 5 | 8 | 1 | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | SII |
| Reinfected | ..... | ..... | 2 | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | SI— |
| | ..... | ..... | ..... | ..... | 2 | 1? | ..... | ..... | ..... | ..... | ..... | ..... | ..... | SI+ |
| | ..... | 2 | 6 | 2 | 2 | 4 | ..... | ..... | ..... | ..... | ..... | ..... | ..... | SII |
| Retreated | 1 | ..... | 2 | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | ..... | SI— |
| | ..... | 6 | 2 | ..... | 2 | 1 | ..... | ..... | ..... | ..... | ..... | ..... | ..... | SI+ |
| | 3 | 11 | 10 | 2 | 2 | 4 | ..... | ..... | ..... | ..... | ..... | ..... | ..... | SII |
| | | | | | | | | | | | 56 SI— | 206 SI+ | 538 SII | Total 800 |

(The faithful cooperation of the succession of resident physicians and nurses who have been or are still on this service, and the laboratory personnel, must be acknowledged—particularly Major John W. Winebrenner, M.C.; Captain Francis G. Sheehan, M.C.; Captain Rolland Deputy, M.C.; Captain William Thompson, M.C.; Captain Perry Seal, M.C., all on active military duty; Louis Y. Mazzini, chief serologist of the Indiana State Board of Health; and Reuben Kahn, M.D., of the University of Michigan, to whose laboratory specimens were forwarded by all of the original Midwestern five-day study group.)

# PREVENTION CLINICS—A STEP IN CANCER CONTROL*

AUGUSTA WEBSTER, M.D.†

CHICAGO, ILLINOIS

The vital statistics have shown a sharp increase in deaths from cancer in the United States in recent years. This is readily understandable because of the increase in skill in modern diagnosis and the prolonged life span of the general population. The tragedy is that so many of these victims do not present themselves for treatment until the advanced stages of the disease; hence, the most skilled medical care is of little value to them. Diagnosis must be made early and adequate treatment given if cancer deaths are to be reduced.

There are numerous clinics already functioning for the treatment and diagnosis of known pathology, but most of these do not make any provision for the apparently normal individuals who are desirous of physical examinations for the purpose of ruling out early cancer. Too often, if symptoms are the impetus which sends the patient to the doctor, the disease has already progressed to a dangerous degree.

Experiments in early detection of cancer, through routine physical examinations, were conducted recently in New York and Philadelphia. Dr. Elise S. L'Esperance founded, in 1937, The Strang Cancer Prevention Clinic, at the New York Infirmary for Women and Children, and in 1940 established similar clinics at the Memorial Hospital. Dr. Catharine Mac Farlane and co-workers in the Department of Gynecology of the Women's Medical College of Pennsylvania, in 1936, undertook to determine the value of periodic examinations in the detection of early cancer of the cervix and cancer of the breast.[1]

The American Society for the Control of Cancer, through its educational unit, The Field Army, has been conducting a campaign of lay education, the keynote of which has been thorough, periodic physical examinations with emphasis on early detection and treatment of cancer. Stimulated by achievements made by the New York and Philadelphia clinics, and sponsored by the Illinois Division of The Field Army, a Cancer Detection Clinic was started in Chicago, May 13, 1943, under the able leadership of Mrs. Arthur I. Edison. Through the generosity of the board of Women's and Children's Hospital, clinic space was granted for this venture. Appointments are made through The Field Army office. The medical social workers, the nurses, and clerical help are also supplied by The Field Army.

Before the clinic was established a plan of procedure was presented to and approved by the Council of the Chicago Medical Society. A committee of six members of the Chicago Medical Society was appointed by the president to act in an advisory capacity to the clinic. This committee has rendered valuable aid in establishing standards and policies.

The purpose of this clinic is to provide periodic examinations for apparently well women, with a view to the early detection of cancer or precancerous lesions. If suspicious lesions are detected the patient is sent to her family physician for care. No treatments of any kind are given by the clinic. Biopsies are not made, because it is the belief of the staff that the private physician should have control over the diagnostic procedures as well as the plans for treatment. Patients are not accepted for examination who are under treatment for cancer. The purpose of this clinic is to detect early cancer and to encourage regular examination. Its purpose is *not* to check upon the diagnosis of other institutions or individual physicians.

The staff is made up entirely of women physicians. Twenty-five in all have participated in the program. The consultants give their time gratis. They represent the various specialties, such as dermatology, gynecology, ophthalmology, otolaryngology, radiology, general surgery, gastroenterology, and internal medicine.

Each patient attends the clinic on two occasions. On the first visit a careful and detailed medical and social history is taken. A complete physical examination is made, with routine laboratory work which includes urinalysis, red and white counts, blood smear, blood serology, as well as cervical and urethral smears. A fluoroscopic examination of the chest is made on all patients. Those who are financially able pay a laboratory fee of five dollars, but anyone who cannot afford the fee is examined without charge.

The findings are summarized for the permanent record, and on the second visit are interpreted for the patient. Re-investigation is made of any major pathology by one or more consultants, depending upon the nature of the findings of the initial examination. A verbal report is made to the patient When an abnormality is found she is told of the nature, but not of the extent of the condition, and is advised to consult her family physician regarding care. She is told that the physician may obtain a detailed report of the examination upon request if he so desires.

Many constitutional diseases in no way related to cancer have been found in the course of the examinations, as well as a few definite malignancies. A number of suspicious lesions have been found which required further investigation. All of these

* Read before The Field Army, Indiana Division, at Indianapolis, March 29, 1945.

† Director, Cancer Prevention Clinic, Chicago, Illinois.

[1] Mac Farlane, Catharine: Periodic Pelvic Examinations, *J.A.M.A.*, Vol. 126, No. 14, 1938.

individuals have been urged to consult doctors of their own choice at an early date. Many apprehensive patients with cancer phobia have been reassured after being carefully examined by one or more doctors and told that they do not have any evidence of cancer.

It is increasingly evident that the public, as the result of lay education on cancer, has been made aware of the desirability of periodic, complete physical examinations. The clinic appointments are now filled for five months in advance, even though patient facilities have been increased to accommodate approximately one hundred new patients each month.

Realizing that prevention clinics have proved their worth and have attracted the attention of the public, these clinics will be organized with increasing frequency. The American Cancer Society, in March, 1934, appointed a committee of six physicians to formulate minimum standards for the establishment of Prevention Clinics. Dr. Bowman C. Crowell, associate director of the American College of Surgeons, is chairman of this committee. The other members consist of Dr. Elise L'Esperance, Dr. Catharine Mac Farlane, Dr. Herman C. Pitts, Dr. Danely P. Slaughter, and Dr. Augusta Webster. Plans have been under discussion by this group for one year. On the fourth of March, of this year, this committee met again in New York, along with several other members of the Executive Committee of the American Cancer Society, to formulate the final draft for the minimum standards. The idea is to safeguard the program but at the same time to leave some elasticity for the local groups to develop their own programs. The following is a resumé of Minimum Standard for Cancer Prevention Clinics, as recommended by the Standards Committee:

*(1) Organization.* A specific plan for the organization and conduct of the clinic shall be approved by the county medical society before the project is made effective, and a medical advisory committee for the guidance of the clinic staff shall be appointed. The clinic shall be conducted in a hospital approved by the American College of Surgeons, or in the outpatient department of a Class A medical school. The medical staff shall adopt rules, regulations, and policies governing the professional work of the clinic, and shall review and analyze their clinical experience at regular intervals. In addition to the medical staff, which shall include representatives of the various branches of the medical profession, a secretary, nurse, and medical social worker shall be available for the purposes of the clinic.

Clause 1—Organization Explanation. The first essential in the organization and conduct of a cancer-prevention clinic is that it shall have the approval of the local medical profession. In some instances it will doubtless be initiated by the local medical society. In others a lay group, perhaps The Field Army, will be the initiating organization. More than in other types of medical service, lay groups will be interested in this type of clinic because of its appeal to foresighted persons to prevent cancer from reaching a serious or incurable stage.

A provision that the clinic shall be conducted in a hospital approved by the American College of Surgeons or in the outpatient department of a Class A medical school is inserted because in such institutions there is a proper measure of control over appointments to the medical staff. Clause 2 of the Minimum Standard for Hospitals approved by the American College of Surgeons reads, in part, as follows:

"That membership upon the medical staff be restricted to physicians and surgeons who are (a) graduates of medicine of approved medical schools with the degree of Doctor of Medicine, in good standing, and legally licensed to practice in their respective states or provinces; (b) competent in their respective fields; and (c) worthy in character and in matters of professional ethics."

The Minimum Standard for Hospitals further stipulates that the medical staff shall, with the approval of the governing board of the hospital, adopt rules, regulations, and policies governing the professional work of the hospital, and that monthly medical staff meetings shall be held, and regular review and analysis made of the clinical work.

It is not required that all members of the prevention-clinic's staff be members of the medical staff of the hospital. It is expected, however, that they shall conform to the policies of the hospital in which the clinic is housed, and that appointments to the medical staff shall be acceptable to the superintendent of the hospital from the standpoint of meeting hospital standards.

Desirable as it may be to have cancer-prevention clinics widely distributed throughout the United States and Canada, in rural as well as in urban communities, it is nevertheless felt that the clinic setup should be safeguarded by placing it in an approved hospital. This requirement is dictated by considerations of proper equipment, proper control, and professional ethics.

It is important that the various branches of medicine be represented on the clinic's staff. Although the purpose of the clinic is to detect cancer, of necessity in order to discover the disease in any part of the body where it may exist, a complete physical examination is required, and other pathological conditions will, of course, be found.

*(2) Equipment.* The equipment shall be adequate for a complete physical examination.

Clause 2—Equipment Explanation. The regular equipment of an approved hospital will suffice for the purpose of a cancer-prevention clinic. This will include equipment for fluoroscopic and x-ray examinations and for making clinical laboratory tests.

*(3) Patients.* All applicants within specified

geographic limits shall be admitted except those who are already under treatment for cancer. Some clinics may be restricted to males and others to females.

Clause 3—Patients Explanation. Patients should not be accepted for examination who are already under treatment for cancer. It is the purpose of cancer-prevention clinics to encourage treatment when the disease is found, but not to check the diagnosis or treatment given by other institutions or by individual physicians. All other patients who apply should be admitted whether or not they are able to pay.

*(4) Records.* There shall be maintained adequate, complete records of patients which shall include identification data, occupation, history, physical examinations with indicated laboratory examinations, summary, and disposition of the patient.

Clause 4—Records. Explanation: Identification data, occupation, history, physical examination, summary, and disposition of the patient should be included in every record. It is good practice to acquaint the patient with the nature of his ailment, if any, but not necessarily of its extent. This applies whether the diagnosis shows a tumor or some other condition. A complete record should be made available only to the patient's physician.

*(5) Disposition of Patients.* Patients who require further diagnostic procedures than are furnished by the clinic, or for whom treatment is indicated, shall be referred back to their physicians. If they have no physician they shall be given a list of physicians or hospitals from which a choice may be made, and to which the findings of the clinic shall be furnished. The clinic shall seek from the physician or hospital a record of final diagnosis, treatment, and follow-up. Patients shall be encouraged to return to the clinic at intervals as indicated for a check-up.

Clause 5—Disposition of Patients. Explanation: Patients who have their own physicians should be referred back to them for advice. The local medical society should furnish the clinic with lists of physicians or hospitals as a guide for patients who have no family physician. Findings of the clinic should be furnished when referred to the patient's own physician, or to the physician or hospital he selects from the list provided. The physicians or hospitals should be asked, as a matter of record, for reports on final diagnosis, treatment, or follow-up. If the diagnosis involves a biopsy and its interpretation, this should be done preferably by the patient's own physician or by the other physician or hospital to which the patient is referred. The biopsy diagnosis should be made by the cancer-prevention clinic only if and when it is so requested by the private physician.

To impress upon patients the desirability of periodic examinations, they should be encouraged to return at intervals for further check-up yearly, or more often if facilities are available.

*(6) Fees.* A contribution of a specified sum of money toward the expenses of the clinic shall be required of patients who are able to pay.

Clause 6—Fees. Explanation: Patients who are able to pay should be asked to contribute a specified amount toward the expenses of the clinic. When further diagnostic procedures are indicated in addition to the regular examination, special supplementary charges may be made.

## CONCLUSION

Step by step in the last decade and a half progress has been made in the treatment and diagnosis of the cancer patient. In 1930 the American Cancer Society appointed a committee to make a study of the best means of improving service to the cancer patient, and requested the American College of Surgeons to encourage the formation of cancer clinics in general hospitals in accordance with the principles of a special minimum standard.

By January, 1944, in the United States and Canada there were three hundred forty-one such clinics approved by the American College of Surgeons, besides thirteen fully-approved cancer hospitals and six fully-approved departmental cancer clinics. There are two such departmental cancer clinics in Indiana; one at the Indiana University Medical Center, and one at the Indianapolis City Hospital. There are two other clinics in Indiana provisionally approved; one is located at the Protestant Deaconess Hospital, in Evansville, and one at the Epworth Hospital, at South Bend.

As realization of the prime importance of early treatment of cancer grew, demand arose for a type of clinic in which the service was limited to diagnosis. By January, 1944, there were thirty-two approved diagnostic clinics.

Patients who were seen in the early cancer clinics were usually in far-advanced stages of the disease when the diagnosis was obvious, and practically all of the effort was centered on treatment. Gradually patients have been seeking advice earlier, and diagnosis is becoming more important and also more difficult, and consequently it is receiving more attention in all clinics.

Now an educated public is asking for services which will antedate that of the diagnostic clinic—a service which will seek, in persons who have all the appearance of being well, the first signs of cancer detectable only through thorough, periodic examinations in which laboratory tests, x-rays and other diagnostic aids are employed. Today the goal is to detect cancer before there are any superficial signs of its existence.

*THE JOURNAL*
OF THE
INDIANA STATE MEDICAL ASSOCIATION
DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA
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**AUGUST, 1945**

# Editorials

## THE MEDICAL CARE SITUATION

It will be recalled that the Executive Committee of the Indiana State Medical Association recently sent out a plea for the return of such Indiana members of the Medical Corps in the armed services as might reasonably be spared from further active duty. This plea was made because of the dire need of additional medical care in Indiana, and it was thought that with the end of the European phase of the war, with the consequent return of so many enlisted men, there might be less need for Medical Corps men in certain areas, and that some of these might be returned to civilian life.

This request, sent to the Surgeons General of the Army and the Navy, as well as to members of Congress, has met with general approval of the Indiana press, as noted in the dozens of clippings received by THE JOURNAL. We, of course, cannot print all of these comments; we can only give a summary of the opinion of editors of papers over the state.

The *Muncie Star* crystalizes this general opinion with some fine comment on the situation. In an editorial therein the editors take occasion to say, "Indiana is entitled to early recognition for release of physicians who are in the armed forces. The state was among the first to fill its quota of doctors, and has never lagged in its requirement. It should be the first to benefit from the return of physicians now in the armed forces."

Later in the article the editor makes it clear that "the Indiana State Medical Association neither asks nor wants the return of a doctor who is needed in the service." This is quite true, as was made very plain in the original plea formulated and sent out. We felt that with the end of the European war there certainly would be a let-down in the number of physicians needed in field service, and it was to this point that our request was directed.

We have consistently opposed any plan whereby Medical Corps men would be transferred into certain other medical services, chiefly the plan once suggested that such doctors be transferred to veterans hospitals — a plan that now seems to have been abandoned.

But even though Europe no longer figures as a battlefield, there remains the other side of the world and its many problems. The war in the Pacific, as it generally has come to be called, is another story; it brings about needs that were not present in the European campaign. We refer to the Navy and its medical needs. We have previously pointed out that several thousand additional physicians had been requested by the Navy, and only recently Surgeon General McIntire sent out a statement in which he declared that the Navy needed three thousand additional doctors, at once. Hundreds of new ships are being put into service, many of which require one or more medical men as a part of their complement. Landing on the various newly-captured islands of the South Seas, and elsewhere, call for the establishment of hospital service, which, of course, calls for medical officers.

Admiral McIntire states that the "new crop" of V-12 men will not be sufficient to supply this need, and that he must look elsewhere for additional medical officers. All these factors further complicate the general situation, but we are in accord with the suggestion of the Indiana press that, as soon as possible, medical officers not actually needed be returned to private duty. And we are in further accord with the suggestion of our press that, since Indiana's record is of the highest order in the matter of enlistments in the Medical Corps of the Army and Navy, it would be only fair to give us a "break" in the matter of discharges from such service.

Be sure to read the annual committee reports in the September issue of THE JOURNAL. During these difficult times these reports are doubly important, and the recommendations will undoubtedly affect every physician in his respective field.

## INTRODUCING RAY SMITH

With the "Lend Lease" agreement with the American Medical Association, whereby Thomas A. Hendricks took over the secretaryship of one of its Councils, there was some speculation as to what might be done to care for the local situation. It was patent that it would require more than a half-time executive secretary to properly look after the affairs of our state association, yet it was felt that the parent body sorely needed the services of Secretary Tom.

Hoosier Medicine is a most resourceful crew and, as usually is the case, finally came up with the answer to the big "sixty-four-dollar question," this by way of appointment of Ray E. Smith as assistant executive secretary. To our mind this is a most happy solution; we have brought to the job a man "who has been around," a man who has been intimately connected with Hoosier politics just long enough to know what it is all about, yet not so long as to be contaminated with the political bug.

He served as secretary to Governor Henry Schricker throughout the term of that most excellent executive, and later was appointed to the State Tax Board, by Governor Gates, serving until June first, when he resigned to take over the new job.

However, his service with us will be on a part-time basis, taking over while Secretary Tom is engaged in his Chicago position. The other half of his time will be utilized in opening up a new medical office in Indiana, that of Executive Secretary to the Indianapolis (Marion County) Medical Society. The latter is one of our most cherished medical dreams, for when our local (Lake County) society took this step several years ago, it was an instantaneous success and through the years has proved to be the wisest thing the Lake County Medical Society ever has done, so we could not but hope that the Indianapolis group might some day see the light and do likewise.

Ray Smith brings a lot of things to Indiana Medicine; he is not too old, yet with enough years to have developed the "go get 'em" ideas that are so sorely needed in professional circles these days. As we have said, his political connections have been such as to give him an acquaintance exceeded only by that of the old "stage horses" in Indiana politics, and as we further have said, he got out in time to make the cure possible.

And not the least of the assets which he brings to us is his former newspaper experiences; these will enable him to be of assistance to THE JOURNAL.

As Ray remarked to us recently, he felt that it was about time he dropped out of active politics and began to look about for a permanent field in which there were possibilities for future developments. We know of no other field in which the future is brighter; medicine is fast reaching the conclusion that lay help is a great desideratum, and the young man with ideas, plus the will to get things done, "follow through" expresses it better, has an almost unlimited field. The entries are not too numerous, and a few fall by the wayside, but in the main the chap who has plenty of "IT" gets around the bases, not forgetting to "touch second" as he goes along.

As must be evident from the foregoing, THE JOURNAL is much pleased with having Ray Smith come to headquarters, even though for but a part-time job, being located in the same building where the Indianapolis group is opening its new office, and where we can feel free to call on him at any time for his guidance and assistance.

Yes, Ray, we most heartily welcome you, and feel secure in the belief that your coming to us will be of much mutual benefit. We assure you of our full support in all your undertakings, and we trust that these will be many.

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## HOMER H. WHEELER

Again we pause to pay final tribute to another stalwart in Hoosier Medicine, a man who had given freely of his time and talents in the furthering of organized medicine in this state. For many years Doctor Wheeler served on the Executive Committee, in that time establishing a record of being present at practically every session of the committee, and being right on time.

He had practiced his profession for some fifty-two years, having been graduated from the old Central College of Physicians and Surgeons, for many years known as the "Eastman School." Soon after graduation he became a member of the faculty of that institution, and it was there we first met him, in 1898.

Later in his professional career he limited his practice to proctology, establishing himself as one of the leaders in that branch of medicine. He also served as a faculty member of the Indiana University School of Medicine, being an assistant professor of surgery for some thirty years. He served as a captain in the Army Medical Corps in World War I.

Of a rather retiring disposition, Doctor Wheeler was of the "quiet" type, yet was a most interesting conversationalist along most any line. For many years he lived at the Columbia Club, and during the many occasions we have met him there we learned much of his daily routine. One of his hobbies that attracted our attention was his fondness for fruit preserves, and each morning the waiter placed on his table a jar of the delicacy. He informed us that a sister saw to it that he always had a sufficient supply in the club storeroom.

Doctor Wheeler drove a car as a matter of course, but he never called it a "car"; he would call the garage and ask that his "machine" be sent over. (Just another of the many eccentricities we elder Hoosiers have!)

In his early career he spent quite some time in the European clinics, preparing for his specialty. Returning to Indianapolis, he at once became inter-

ested in organized medicine, and in his quiet way contributed largely to our present state. Thus, we add another name to the list of Hoosier medical notables, men who have done much to bring about our present organization.

## A FURTHER REPORT ON MALARIA

Since the recent publication of our comment on malaria, in Indiana, we have received from Surgeon General Kirk some interesting and informative material. He declares that "fear, due to lack of information, can cause more harm than the malaria itself." He states that the soldier who fears malaria will suffer more ill consequences than the man who understands that with proper care this disease is not of serious import from the standpoint of the patient's general health.

The General also admonishes that we civilians who have these cases come into our midst should not be too fearful of the result, provided that the patient is under proper care and treatment.

Of the several types of malaria, the two with which the Army and the Navy are most concerned are the benign tertiary malaria and the malignant tertiary malaria. Without treatment, the latter may be fatal. It is believed that the type of malaria chiefly affecting the returning servicemen will be the benign tertiary malaria.

It has been found that servicemen affected with the benign type are able to carry on combat duty as long as they take the required dosage of atabrine. This drug, however, rarely cures the benign type; it merely suppresses it.

In the majority of cases the disease will have run its course after the man has had a few relapses, and no permanent damage has been done. The number of these relapses vary; of one thousand cases about one-third will have but one attack, about forty will suffer ten relapses, and about one will have as many as twenty attacks. These "follow-up" attacks cause only a brief period of inactivity on the part of the patient.

The Anopheles mosquito, long believed to be the sole means of infection, continues to be thus regarded. Army observers believe that this pest can pick up and transmit malaria only when it has bitten a patient suffering a relapse.

We are glad to learn that the yellow color of the skin in those taking regular doses of atabrine is but of transient effect, and that it will disappear soon after stopping the use of the drug. A member of our family, on Okinawa, wrote that when he arrived there his skin was very dark, almost black, following several months of service at Pearl Harbor, but that now it is a definite yellow—"look like a Jap," he said. He had been told by the Medical Corps that this condition was due to atabrine, but evidently had not been informed that it would clear up.

Another interesting comment in the article by General Kirk might well be quoted: "Infected individuals who are not taking regular suppressive treatment are particularly subject to relapses if they engage in strenuous work, suffer from exposure, or if they indulge in drinking to excess."

It is officially stated that deaths due to malaria, during the present war, have been rare. Cases that have had reasonably early treatment and which have not been complicated by other conditions usually recover. The General concludes his statement with a striking observation, "In the early stages of the Pacific war, malaria did more damage to American soldiers than Jap bullets in disabling troops, not in killing them."

## Editorial Notes

Major General George F. Lull makes the flat announcement that additional United States Army Medical Corps officers will not be assigned to duty with the Veterans' Administration unless they previously have served on the staff of that organization.

The Terre Haute Y.M.C.A. has a novel plan of health education for this summer. There will be a series of ten talks by local medical men, these meetings being held on consecutive Thursday nights. As a local paper expresses it, "The ten lectures will be planned so as to formulate one big story, starting with the skeleton and ending with the biology of life." Properly presented—and we are sure that it will be after looking over the list of speakers, this program is sure to meet with the hearty approval of those who attend the meetings, and it also is certain that those who attend the initial meeting will want to attend each successive one, so that they may hear "what comes next."

We finally have decided what to do about our vacation this year, which is practically nothing. Several weeks ago we foresaw a clamp-down in civilian train travel; hence, did not bother to write our favorite Canadian resort for a reservation, deciding that the proper thing to do was to stay home. If we can manage to do so, we want to get away from the office for a week or so, and try to catch up on our reading, along with other things, but "Mom" has laid out a program which cannot wait and which will take most of the allotted time. It certainly is odd how many chores develop about the modern home, in these days when repairmen are hard to locate. This window needs this, that door needs that, and so it goes. We also plan to wrestle with some wood taken from an old cottonwood that we are having removed. With the help of three grandchildren, war babies, we expect to accomplish wonders this summer—so much so that we may eschew vacations for all time to come and just stay at home and do chores.

Five of America's best-known psychiatrists are now touring all Army headquarters installations in Europe, to study the psychological factor in the combat infantry soldier, and methods of psychiatric treatment now in use. The final report of these studies will make a valuable contribution to our knowledge of this interesting subject.

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Maurice Early, of the *Indianapolis Star*, advises that the Indiana tomato crop for the current year will be about normal, which means that Indiana again takes the lead in the production of this noble fruit and its by-products. Early in the season it was feared that weather conditions would sharply interfere with this industry, but it now appears that all is well, and good growing weather has set things aright.

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Our local garden report is rather good; the early crops did very well, and the current one seems to be a bit above the average. We rather concentrate on tomatoes this year, for several reasons. We are trying some of the newer varieties, particularly the hybrids, and also are doing a bit of experimenting with the hormones. Much has been written in recent garden magazines about this subject. The treatment consists in spraying the blossoms, especially the earlier ones that usually drop off, with a solution—used sparingly in an atomizer. It is promised that the yield will be increased; the early blooms will fruit, and the tomatoes will be seedless. We also are trying this on our green peppers and the new hybrid cucumbers. We will report later as to how we come out with these experiments.

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We continue to hear much concerning the wonders accomplished by the use of penicillin, as well as about some of the things in which it has been found inefficacious. Now comes a comment from the United States Public Health Service relative to the "hurry-up" treatment of gonorrhea. The results of such treatment in more than two thousand cases are reported, these cases having received a single injection, in oil, plus three injections, employing water solutions of penicillin. The service concludes that such treatment is effective, safe, and widely applicable. The success per cent ranged from 96.0 to 84.3, in the four institutions in which the experiments were carried out. A second group of one thousand and sixty cases, treated by physicians over the country, is reported, these cases being given a single intramuscular injection of penicillin calcium, suspended in an oil-beeswax mixture. The reports indicated that success resulted in 91.2 per cent of the cases. A third group, all women, was treated by the same method in the United States Public Health Medical Center, at Hot Springs, showing a large percentage of cures. Thus, it would seem that pencillin is to play a most important role in the management of this disease.

We read about the use of milk by wounded men aboard ship bound for this country; just how it was managed to give them "fresh milk." Now comes the information, via an official source, that the milk used is fresh frozen milk, and that it tastes just as fresh after three or four months of freezing as if it had just come from the cow. It also is found that the bacterial count is much lower in frozen milk than in fresh milk. Just another bit of evidence that freezing of foods will play a mighty important part in the production, sale, and use of our foods, once the proper equipment becomes available.

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*The Sullivan Union* recently carried a column about the old-time "Indian Shows," these events being quite familiar to those of us in the upper age brackets. The writer also comments on the "street shows," where patent medicines were handed out for a small consideration. "Sagwa Tea," "Lone Star Indian Tea," tape worm treatments, et cetera, were featured by the itinerant "doctors," all of whom seemed to have adopted a high-sounding name. Well do we recall that in our early days such a show would hold forth in the local schoolhouse, often a one-room affair, being attended nightly by almost everyone who was able to walk to the building. Later on these folks came to the small towns in an open carriage, usually with a banjo player strumming his instrument as they rode through the town. The "Doc" always wore a silk hat, a flowing tie and a Prince Albert coat, with striped trousers. In later life we had occasion to talk with a few of these men, then retired, and as raconteurs we found them most entertaining.

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We've become accustomed to reading news stories about the large number of deer now found in Indiana, particularly the southern section. In fact, we have seen a few such animals down there in the past few years. And we are, of course, quite familiar with the step-up in the number of worthwhile fish to be found in Indiana waters these days, as well as the increase in game birds. Now comes a story, or rather a complaint, about the beavers. It seems that only a short time ago a few of these animals were brought into northern Indiana, and now they have increased in numbers to such an extent that in some sections they are just "raisin' Ned." They are building their dams in some small streams adjacent to the muck-land country, causing these streams to overflow, with consequent damage to crops. Farmers concerned are asking the Conservation Department to do something about it, suggesting that the beavers be moved elsewhere. They are busy little animals, as we often have observed in our North Woods trips. We recall seeing the beginning of a beaver dam in the Star Lake country in Wisconsin some years ago. The next year the small stream leading into our favorite walleye lake had been entirely closed, and our only means of access thereto was by a trek of several miles via a log road.

# President's Page

## SOMETHING TO CHEER ABOUT!

The Council on Medical Service and Public Relations and the Board of Trustees of the American Medical Association has brought out a program that should provide a sound working basis upon which to build future plans for American medical practice. The men who compose this council are to be congratulated upon their farsightedness and the manner in which they have compressed a world of determination into fourteen spheres of constructive activity. For the endless amount of time and effort they have thrown into the work of offering a good, basic program for the American people, the entire profession owes an unlimited amount of thanks. They are busy practitioners, just as we are, and yet they have sacrificed their time and a great deal of income to be able to present to the American doctor a program that all of us can get behind and support.

The constructive program is as follows:

**1. Sustained production leading to better living conditions with improved housing, nutrition and sanitation which are fundamental to good health; we support progressive action toward achieving these objectives.**

**2. An extended program of disease prevention with the development or extension of organizations for public health service so that every part of our country will have such service, as rapidly as adequate personnel can be trained.**

**3. Increased hospitalization insurance on a voluntary basis.**

**4. The development in or extension to all localities of voluntary sickness insurance plans and provision for the extension of these plans to the needy under the principles already established by the American Medical Association.**

**5. The provision of hospitalization and medical care to the indigent by local authorities under voluntary hospital and sickness insurance plans.**

**6. A survey of each state by qualified individuals and agencies to establish the need for additional medical care.**

**7. Federal aid to states where definite need is demonstrated, to be administered by the proper local agencies of the states involved with the help and advice of the medical profession.**

**8. Extension of information on these plans to all the people with recognition that such voluntary programs need not involve increased taxation.**

**9. A continuous survey of all voluntary plans for hospitalization and illness to determine their adequacy in meeting needs and maintaining continuous improvement in quality of medical service.**

**10. Discharge of physicians from the armed services as rapidly as is consistent with the war effort in order to facilitate redistribution and relocation of physicians in areas needing physicians.**

**11. Increased availability of medical education to young men and women to provide a greater number of physicians for rural areas.**

**12. Postponement of consideration of revolutionary changes while 60,000 medical men are in the service voluntarily and while 12,000,000 men and women are in uniform to preserve the American democratic system of government.**

**13. Adoption of federal legislation to provide for adjustments in draft regulation which will permit students to prepare for and continue the study of medicine.**

**14. Study of postwar medical personnel requirements with special reference to the needs of the veterans' hospitals, the regular Army, Navy, and United States Public Health Service.**

This represents the most forward-looking, aggressive step ever sanctioned by the American Medical Association. It implies a tremendous amount of work and cooperation from every state and county medical organization in the country. Let's back this fine, worth-while effort of the Council on Medical Service and Public Relations by a solid, united endeavor to make this program succeed. This is really something to cheer about!

N. K. Foster

# A PROGRAM OF ADEQUATE MEDICAL CARE FOR INDIANA*

GUY W. SPRING, Executive Director, Blue Cross Hospital Service

INDIANAPOLIS

A program of medical care which would contemplate the inclusion of all the people of the State of Indiana is much more far-reaching than the average individual might suspect. Therefore, it would seem practical to lay down a definite pattern for such a program before attempting to analyze any of its related parts.

First of all, what is meant by adequate medical care? To me, as a layman, it is a program for maintaining a uniformly high level of health, a program which provides necessary medical care in or out of the hospital for all the individuals who constitute the community.

The elements which make up such a program are so closely related that they tend to overlap in many important respects. These elements are:

1. Medical care in the home and in the doctor's office.
2. Surgical and obstetrical service.
3. Hospital care.
4. Clinical diagnostic service.
5. Nursing care in the home and in the hospital.
6. Dental service.
7. Health research.

For example, it is very difficult to separate hospital care from medical, surgical, diagnostic, and nursing service. The hospital, in the final analysis, is a modern, practical, sanitary institution in which the doctors provide the same service with immeasurably greater efficiency than that which they performed years ago in the home. The patient's bedroom was formerly his hospital room; some member of the family or a neighbor was his nurse; the kitchen, with its table and sink, was the operating room and laboratory.

Over the past quarter century the hospital has become the health center in the community. Today, in this country, we have more hospitals rendering a higher quality of service than anywhere else in the world. Indiana has shared well in this great development. The facilities for all of the elements of a program of complete medical care are here. In some sections of the state they are not fully adequate, but steps are rapidly being taken to correct this situation.

All of the elements which enter into such a program as has been outlined are interdependent, one upon another. In Indiana the coordination between them is well developed, and is constantly being refined. Therefore, in Indiana we have the facilities, the professional talent, and the lay personnel necessary to provide an adequate program of medical care. Yet we all know that many of the people do not now, and never did, receive more than a bare minimum of medical care. Adequate medical care has been available only to the rich and to the indigent in normal times. The great middle class and the industrial workers that make up the very backbone of the state and the nation—those who are called upon to produce the instruments of war and peace—often do not receive proper medical care.

The fact that at present, in our greatest era of prosperity, a larger proportion of industrial workers are securing hospital and medical care indicates their full awareness of their needs. However, it is in this group that we find the greatest suspicion and animosity toward doctors and hospitals. However, once we dig to the root of this feeling, we find that in reality few question the quality of service rendered by a hospital, or the professional ability of the physician. It is believed that the costs are too great, but it is rarely expressed in those terms by proud Americans. The industrial workers have a feeling of resentment if saddled with debt resulting from no fault of their own. Unexpected illness in the family which requires hospital and medical care is responsible for many such debts.

On the whole, the costs of medical care are not exorbitant. It is their unpredictable nature that makes them seem so. The average industrial worker with a family will spend at least twenty cents a day, or seventy-three dollars a year, for bread. Yet, he does not believe that the price of bread is too high. On the other hand, if he were required to pay the seventy-three dollars all at once, he would be incensed, just as he now is when faced with a surgical or hospital bill of seventy-three dollars or more, and does not have the cash with which to pay it.

Therefore, the problem of providing adequate medical care to the masses is to provide a means for the people as individuals to finance such care. That this is the nub of the whole problem has been generally recognized in the past few years. The hospitals were the first, apparently, to recognize it, and to try to do something about it. They hit upon the prepayment plan as the answer, and developed the Blue Cross Plan as the instrument. Later, the doctors seeing the merit of such a plan, established similar organizations through state or county medical asociations in many parts of the country.

The American Dental Association also has recognized that the problem of the middle- and low-income groups in availing themselves of proper dental care is in the financing thereof. As a result, the Council on Dental Health has been established to make recommendations for an experimental prepayment dental plan.

Both management and labor have supported the nonprofit prepayment plans in a gratifying manner. However, some two or three years ago, in the

* Presented before the Indiana Health Council, at Indianapolis, on April 20, 1945.

belief that the voluntary plans were not progressing rapidly enough, organized labor threw its weight behind a proposal to extend the Federal Social Security Program to embrace a program of compulsory health insurance.

The phenominal growth of Blue Cross in the last two years has tempered the feeling of labor somewhat. For example, when Robert K. Lamb was testifying before a Congressional Committee for Philip Murray, president of the Congress of Industrial Organizations, a discussion arose as to the method of financing health care. A committee member asked Mr. Lamb whether his organization is convinced that compulsory health insurance is the only solution, and he replied with this challenging answer: "The people for whom I am speaking still feel that voluntary health insurance will not be sufficient, but they also believe that those who advocate voluntary insurance should have an opportunity to demonstrate its adequacy."

In reality, the voluntary plans are being watched and are being encouraged from every quarter. Consequently, we in the health field, both professional and lay people, have the opportunity of solving one of the most pressing problems of the nation—that of providing the means for the people as individuals to finance adequate medical care for themselves and their families. The Blue Cross Hospital Service Plan, and to a lesser degree the Medical Service Plan, have pointed the way.

As we indicated above, the average worker does not consider twenty cents a day for bread to be too high. Therefore, is there any reason to believe that he would consider twenty cents a day too much to provide adequate medical care for himself and his family? Hospital care has been offered through Blue Cross for about five cents a day, and 17,000,000 Americans have availed themselves of the privilege of membership. Now, what could we in Indiana do if all of our industrial workers were to offer us twenty cents a day to build a program of adequate medical care for them? The Bureau of Labor Statistics reported that there were 1,051,000 gainfully employed people in Indiana in November, 1944, exclusive of farm workers. At twenty cents a day this group would provide nearly $78,000,000 a year for their health needs. The farm group would substantially increase this amount, but I will confine this discussion to the industrial group. It is estimated that a program of care including surgical, obstetrical, and medical care for hospital patients could be provided to the industrial group for approximately $50,000,000, thus leaving a balance of nearly $28,000,000 for the other elements of the program which has been outlined.

Under such a comprehensive prepayment program the status of the participants would remain exactly as they are today. The relation between the individual and his doctor, his hospital, his dentist, and his nurse would be unchanged. Just as the hospitals have joined forces to organize the Blue Cross Hospital Service Plan, the doctors, as they now have under consideration in Indiana, would establish their own organization; likewise would the dentists and the nurses. Thus, each professional group would handle its own professional problems. All would coordinate their efforts to solve the problem. To work in coordination does not mean that any one group would work in subordination to any other group or groups.

A coordinating agency would handle the collection of the fees and the payment for the services, in order to simplify the program for the worker and the employer. The worker would not like four or five separate deductions from his pay check, and his employer would likely refuse to make them. The coordinating agency would bill all of the services together, and the fees would be collected by one deduction. The coordinating agency would not be in control of the hospitals or the doctors, dentists, or nurses. These separate groups, on the contrary, would control the coordinating agency.

In this manner, by joint effort and cooperation, a sufficient income could be obtained to provide all of the services which have been outlined, and allow for generous appropriations for research through established and recognized research organizations in Indiana.

To demonstrate the practicability of such a comprehensive plan, let us take Blue Cross as the example: The hospitals knew that one out of every ten persons was being admitted to hospitals each year. Furthermore, they knew that many others required hospital care, but did not get it because they could not afford it. They knew that less than 10 per cent of those admitted to hospitals had the actual cash with which to pay their bills, and that the balance was forced to give up some possession or mortgage their future income in order to meet the unexpected cost of hospitalization. They then set down the requirements for the solution of this problem, as follows:

> First, that a plan be developed that would provide hospital care at a cost that was moderate and within the means of everyone to pay. It was found that hospital care could be provided on a prepayment basis for employed people and their immediate families for as little as $1.50 a month.
>
> Second, the plan must provide protection for the worker and his immediate family under one membership certificate. This is imperative because 76 per cent of all those admitted to hospitals are women and children. The Blue Cross Family Certificate provides coverage for the man, wife, and all unmarried children under the age of nineteen.
>
> Third, the plan must pay the hospital bill in full. This is important because hospital bills are so variable. The Blue Cross Certificate provides and pays in full for all hospital services and all professional services provided by the hospitals with the exception of two, and generous allowances are made for these.
>
> Fourth, the plan must make it easy for people to get in and out of the hospitals. Each member

has his own identification card which is presented at the time of admission. The member is assigned to a room immediately, without question. When he leaves he merely signs his bill to certify that he has received the service. There are no forms to fill out, no claims to file, and no red tape.

Blue Cross already has paid hundreds of hospital bills for its members. Some have amounted to as much as $370 for one admission. Not a single member has yet indicated that he thought his bill was too high. Conversely, many have sung the praises of the plan and of the hospitals that have rendered this service. There is no reason to believe that the reaction of the people would be any different toward surgical or medical charges if a means were provided them to budget for those charges in advance.

Those who fear state medicine may be inclined to regard this whole suggestion as grandiose and visionary, or—even worse—as a means through which an agency would be established which the government could seize as the instrumentality through which to put state medicine into effect. But the fear of the plan merely on the ground that it is gradiose, visionary, and impractical disappears in the presence of the accomplishments of the hospital service plan which I have pointed out.

Likewise, the fear that state medicine would be hastened by the plan I have outlined disappears when we consider the manner in which the government acquired control in the field it has already pre-empted. In no case did it seek for an existing agency; rather, a bureau head was appointed to organize a governmental agency from the ground up. This is not a difficult procedure. It is even more desirable to politicians, for it offers an immediate opportunity for extensive personal patronage. But where an existing agency is functioning satisfactorily to the public at large, it offers no allurement to the politician to attempt to take it over. If the public is satisfied it will resent government interference, and satisfaction on the part of the public, with an existing plan, is a safeguard against government encroachment. The people do not want state medicine, but they want medical care. The medical profession is in a better position than the laity could possibly be to develop a plan through which medical care can be made satisfactorily available to all the people. The same thing can be said of the nurses and the dentists with respect to their professions.

The public prefers nongovernmental methods so long as the service they are demanding can be obtained through private organizations, but will not hesitate to seek government assistance if the service cannot be, or if they fear it cannot be, obtained in that manner. The fact that medical service plans already are operating successfully in many parts of the country would indicate that it is as practical to develop a plan for the prepayment of medical care as it is for hospital care.

In summary, I believe that it can be said that the need for such a comprehensive program as I have outlined is generally recognized; that the masses have expressed a desire—even a demand—for it, and that the entire problem revolves around the financing of such a program.

There are two alternatives to its solution: (1) through a voluntary program providing a means for the people to prepay the cost of their medical and hospital care; and (2), a program of compulsory health insurance administered by the Federal Government. Hence, we in the health field now are faced with our greatest challenge.

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## ABSTRACTS

### U. S. DOCTORS BANNED IN MEXICO

United States physicians are virtually excluded from practicing medicine in Mexico, *The Journal of the American Medical Association* reports in its June 2 issue. According to *The Journal's* Mexico City correspondent, a new and rigid federal law, designed to eliminate foreign influences from the Mexican scientific professions, went into effect on May 28. The law, which lays down a complete system of control for a number of professions, is important in its limitation as far as American doctors are concerned. The statute declares that "no foreigner can practice, in the Federal District and territories, the scientific professions covered by this law." The medical profession is particularly named as one of the fields which has been closed to foreigners.

American physicians already practicing in Mexico, however, probably will not be affected, government sources indicated. These doctors, who comprise some of the country's leading medical authorities, may be required to register their qualifications with the General Bureau of Professions, the government agency which will administer the legislation. Another exception will be made for refugee physicians, who will be conceded "temporary permits" to practice, provided they are able to "prove themselves to be the victims of political persecution in their own country."

### INFANT MORTALITY RISES IN FRANCE

In a statement from its Paris correspondent, *The Journal of the American Medical Association* for June 16 reports that the infant mortality in France during the war has increased 40 per cent.

The Paris letter states that "37,000 children have been abandoned, compared to 20,000 in 1936; the number of delinquent children has advanced during the same period from 12,000 to 36,000; the assistance organizations at present have in their charge more than 200,000 minors but are far from having sufficient resources and equipment necessary to accomplish this hard task.

"Infant mortality has increased 40 per cent; cases of typhoid have doubled, those of diphtheria have tripled; cases of tuberculosis have increased by about 11 per cent on the average, but in Paris by 48 per cent and at the mouth of the Rhone (Marseilles) by 74 per cent.

"It seems that there had been a sort of epidemic of serious tuberculosis; all those who did not have sufficient resistance having been decimated, the surviving ones were less vulnerable. But it is now already certain that the mortality figures of tuberculosis in France for the years to come will be above all those recorded up to now."

## NAVY'S RESPONSE TO OUR APPEAL FOR RELEASE OF MEDICAL OFFICERS

*The following response has been received from Vice Admiral Ross T. McIntire, Surgeon General of the United States Navy, concerning the appeal made by the Executive Committee of the Indiana State Medical Association for the release of medical officers not needed by the armed forces:*

**BUREAU OF MEDICINE AND SURGERY**
**Department of the Navy**
**Washington, D. C.**

6 July 1945

Executive Committee,
Indiana State Medical Association,
Indianapolis 4, Indiana.

Gentlemen:

This will acknowledge receipt of your statement relative to the release of medical officers by the armed forces, dated 18 June 1945.

The Bureau of Medicine and Surgery concurs in the resolution adopted, as expressed in the last paragraph of your letter. However, it is considered necessary to advise relative to the medical personnel situation in so far as it pertains to the United States Navy:

The advent of V-E Day unfortunately did not relieve the medical personnel situation in the Navy, in that the majority of naval activity has been concentrated in the Pacific area. At the present time there is a critical immediate need for three thousand medical officers to fill existing billets in newly-commissioned ships, Marine Corps activities, foreign bases, and Medical Department activities within the continental limits of the United States.

The Bureau of Medicine and Surgery and the Bureau of Naval Personnel is exerting every effort in connection with procuring civilian physicians for appointments in the Medical Corps of the Naval Reserve to meet this immediate demand for medical personnel, to give adequate medical attention to personnel of the Navy, Marine Corps, and Coast Guard. The present V-12 program has been so restricted that there is not a sufficient number of graduates to meet the immediate needs of the Medical Department due to the ever-increasing number of ships and naval activities and the high attrition of medical officers.

The Bureau of Medicine and Surgery wishes to take this opportunity in expressing appreciation for the unusual cooperation rendered to the Medical Department of the Navy by the Indiana State Medical Association in the procurement of medical officers. You may be assured the Medical Department of the Navy will make every effort to release medical officers to civilian activities at the earliest practicable time consistent with the exigencies of the service. With kindest regards,

Sincerely,
Ross T. McIntire,
Vice Admiral (MC)
Surgeon General, United States Navy.

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## LETTER FROM SENATOR WAGNER AND ANSWER BY EXECUTIVE COMMITTEE

*Letter received from Senator Robert F. Wagner concerning Bill No. S. 1050, entitled "The Social Security Amendments of 1945," and introduced in Congress by Senators Wagner and Murray, is published herewith, together with the reply made by the Executive Committee of the Indiana State Medical Association.*

**UNITED STATES SENATE**
**Washington, D. C.**

May 31, 1945

Thomas A. Hendricks, Managing Editor,
THE JOURNAL of the Indiana State Medical Association,
Indianapolis, Indiana.

Dear Mr. Hendricks:

On Thursday, May 24, I introduced with Senator Murray a bill, *S. 1050*, entitled: "The Social Security Amendments of 1945." The bill provides for "the national security, health, and public welfare."

Representative Dingell, of Michigan, introduced a companion bill *(H. R. 3293)* in the House at the same time.

I am forwarding the bill itself, and a copy of my speech in the Senate for your information and use.

I particularly invite your earnest study of the provisions of the bill relating to health. There is absolutely no intention on the part of the authors to "socialize" medicine, nor does the bill do so. We are opposed to socialized medicine or to state medicine. The health insurance provisions of the bill are intended to provide a method of paying medical costs in advance and in small convenient amounts.

During the formulation of this bill, we have benefited greatly from the constructive advice and suggestions of practicing physicians, and of physicians in clinical and teaching positions. Their constructive suggestions have resulted in changes in the bill which we presented in the last Congress. Undoubtedly other changes will be made before this bill is enacted into law. We wish to have it known that we invite constructive suggestions from the medical profession.

In addition, members of the medical profession will be given full opportunity to voice their opinions in open hearings when the bill is considered in Committee.

I hope that you will print this letter in your Journal, and that you will join me in urging the medical profession to undertake an earnest study of the actual provisions of the bill. In this way you can help immeasurably in avoiding misunderstanding and misinterpretation of the legislation, and in stimulating physicians and medical and hospital organizations to come forward with constructive suggestions and advice.

Sincerely yours,

ROBERT F. WAGNER

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## INDIANA STATE MEDICAL ASSOCIATION

July 17, 1945

Senator Robert F. Wagner,
United States Senate,
Washington, D. C.

My dear Senator Wagner:

Your letter of May 31, 1945, regarding *Senate Bill 1050* entitled "The Social Security Amendments of 1945" was brought to the attention of the Executive Committee of the Indiana State Medical Association at its last meeting. Here is a summary of the views expressed by the members of the committee in regard to your letter.

First, the committee appreciates greatly receiving your letter. The members were pleased to have your direct statement that the authors of the bill have no intention to "socialize" medicine and are opposed to socialized or state medicine. They fear, however, that the measure in its present form would produce that result, even though such a result was not intended.

The Executive Committee feels that physicians are in a better position than anyone else to foresee the results of any plan having as its object the supplying of adequate medical care to the whole population. The American Medical Association is the most reliable and dependable source from which to obtain the aid of the medical profession in working out a plan that would make adequate medical service available to all, and at the same time preserve conditions which will stimulate the medical profession to continue the advancement in science, skill, and technique which has characterized it throughout the years.

The Executive Committee, speaking for the profession in Indiana, hopes that whatever may be done in the field of legislation, within which *Senate Bill 1050* falls, will be in a form that will meet with the approval of the medical profession. Those who are interested in that field of legislation should not overlook the fact that the medical profession itself must be preserved at the highest possible degree of skill and ability as the first essential in making adequate medical care available to all. If that is not done, then adequate medical care would be available to no one—and to do that requires that the medical profession be independent and free from regimentation.

Yours sincerely,

EXECUTIVE COMMITTEE,

C. A. NAFE, M.D., *Chairman*
C. H. MCCASKEY, M.D.
N. K. FORSTER, M.D.
J. E. FERRELL, M.D.
F. T. ROMBERGER, M.D.
THOMAS A. HENDRICKS,
*Executive Secretary.*

# Military News

Dr. Joseph Flora, of Peru, has been transferred from Camp Rucker, Alabama, to Camp Shelby, Mississippi.

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Lieutenant Commander Carroll O'Rourke, of Fort Wayne, has been transferred to Great Lakes, Illinois, from Norfolk, Virginia.

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Captain Otis R. Lynch, of Marengo, has been transferred from Fort Ord, California, to an evacuation hospital at Fort Jackson, South Carolina.

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After sixteen months overseas in the Caribbean area, Captain Orville A. Hall, of Muncie, has been home on a forty-five day leave.

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After spending eighteen months in Italy, England, and France, Captain John B. Berkebile arrived in Peru the first of May for a surprise visit with his family. He returned by plane.

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Another physician who has been awarded the Bronze Star for meritorious achievement is Captain Casimir Libnoch, of South Bend, who is in France.

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Major Harold D. Pyle, of South Bend, spent most of June at his home on sick leave after having an operation at the Gardiner General Hospital, in May.

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Lieutenant Colonel James V. White, of Terre Haute, has been awarded the French Croix de Guerre with a gold star, for meritorious service in action. Colonel White has been overseas eighteen months.

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Colonel John E. Owen, of Indianapolis, was home in June on a leave. Colonel Owen is commanding officer of the Valley Forge General Hospital, at Phoenixville, Pennsylvania.

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After returning from overseas, Major Alexander T. Ross, of Indianapolis, has been assigned to the Neurology Branch of the Neuropsychiatric Division in the Surgeon General's Office at Washington, D.C.

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On June twenty-first Captain Bernard Hyman arrived at his home in Indianapolis after spending thirty-two months with the Persian Gulf Service Command, in Iran. He was on duty with the EENT section of a station hospital. At this time it is not known where his new station will be.

The War Department has announced that Dr. Jack Pilcher, of Indianapolis, has been promoted from major to lieutenant colonel.

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After training at Northwestern University, Lieutenant Wendell E. Brown, of Indianapolis, left recently for his second tour of foreign duty. He is now stationed with a Navy Epidemiology Unit in the Philippines.

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Lieutenant Paul L. Stier, of Fort Wayne, is now with the office of Naval Officer Procurement at Seattle, Washington. Lieutenant Stier's former address was a San Francisco F.P.O.

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After a two-year tour of duty in the South Pacific, Lieutenant Commander E. Rogers Smith, of Indianapolis, has been home on a ten-day leave, and is now stationed at the Naval Hospital Center at Bethesda, Maryland.

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Major Hubert T. Goodman, of Terre Haute, has been promoted to the rank of lieutenant colonel. Colonel Goodman is serving with the Chinese Training Center, United States Forces, China Theatre. He has been overseas since September, 1943.

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Dr. Richard Buckingham, of Bloomington, has been promoted to captain, and has received the Purple Heart for wounds sustained last November when a robot bomb hit the hospital in Belgium where he was stationed. Doctor Buckingham is a 1942 graduate of the Indiana University School of Medicine.

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We have learned that Major F. N. Daugherty, of Crawfordsville, is now at the Station Hospital, Vigo Plant, C.W.S., at Terre Haute. Major Daugherty has been back in the United States for approximately six months after having been overseas for many months.

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When a Japanese suicide plane crashed in the *U.S.S. Comfort*, a fully-lighted hospital ship, Captain Lee J. Maris, of Attica, was most fortunate in spite of injuries in that he was the only Hoosier in the medical staff to escape death. Captain Maris was chief of the orthopedic section and in charge of the x-ray department, and was examining an x-ray film when the suicide plane crashed through the operating room into a ward filled with wounded men on the next deck below. He was flown to a base hospital in the Hawaiian area after receiving treatment aboard the ship.

Lieutenant Commander John W. Ferree, of Indianapolis, has been assigned as Officer-in-Charge of the Venereal Disease Control Section, Navy Bureau of Medicine and Surgery. For several months before his new appointment, Commander Ferree had served as Venereal Disease Control Officer for the Thirteenth Naval District, Seattle, Washington. Commander Ferree was formerly State Health Commissioner of Indiana.

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As division surgeon with the Eighth Infantry Division, Lieutenant Colonel Robert E. Daniels, of Decatur, found that the "cease fire" order in Europe brought him immense medical problems in that his department became responsible for some fifteen thousand German battle casualties in twenty-six military hospitals, medical and sanitary supervision for more than two hundred thousand prisoners, as well as medical care, sanitary measures, and prevention of disease among many thousands of displaced persons, and the functioning of five civilian hospitals. This task must, of course, be accomplished without impairing medical service to American forces, and to do it successfully Colonel Daniels pressed into service many German medical officers and the complete personnel of several captured divisions, as well as civilian doctors and nurses.

*Brigadier General Fred W. Rankin (left), the Director of the Surgical Consultants' Division of the Army Medical Department, watches as Corporal Sal Casciorizzo, of Long Island, New York, (in plane), and Staff Sergeant Edward Steffen, of Shawano, Wisconsin, (right) load the first shipment of whole blood that will last twenty-one days. The plane took off from the Air Transport Terminal at Gravelly Point, Washington, D. C.*

Lieutenant Richard H. Gwartney, of Muncie, is with the station hospital at Fort Sheridan, Illinois. He was formerly at Carlisle Training Barracks, Carlisle, Pennsylvania.

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We were pleased to receive a letter from Captain D. J. Steele, of Greencastle, who said: "This is to let you know that I have been transferred from Gunter Field, Montgomery, Alabama, to the Station Hospital, Camp Blanding, Florida—out of the Air Corps to the Army Service Forces.

"I am very pleased with this change and believe that the move was for my betterment. This hospital is large and has a very competent staff. Captain Lawson F. Smith, of Indianapolis, is also here. This latest unit of thirty doctors was sent here to open a Separation Center, and is just getting started.

"My June issue of THE JOURNAL arrived this week. It is nice to read of my friends, and where they are."

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A brief visit to Indianapolis has been made by Colonel James W. Duckworth, who was released by the American Rangers in September, 1944, after nearly three years' internment in a Japanese prison camp. On February 8, 1942, Colonel Duckworth surrendered his hospital unit on Bataan to a Japanese general. For the first year—until January, 1943—he retained administrative control of his unit, but from that time on he was treated as any prisoner.

On July 1, 1942, Colonel Duckworth and his staff were sent to Camp O'Donnell to care for five thousand sick Filipinos. At that time the death rate was two hundred a day, but within the next sixty days it had been reduced to one. In the six months that they were interned at O'Donnell they cared for fifteen thousand Filipinos.

Colonel Duckworth had only the highest praise for the Filipino citizens, stating that at great risk to themselves they aided prisoners of war, and it was his honest belief that they went hungry and often impoverished themselves in order to aid the prisoners. Colonel Duckworth lost seventy pounds during the time of his imprisonment.

In addition to starving their prisoners and committing other atrocities well known to the American people, the Japanese evaded the clause of the Geneva Conference requiring that a prisoner-of-war receive his regular rate of pay. Instead of the 740 pesos that Colonel Duckworth should have been paid each month, he was given forty pesos and showed a book crediting the rest of his pay in Japanese postal savings, which they said could be collected at the end of the war.

Colonel Duckworth was a practicing physician in Indianapolis prior to entering service in 1917. Although he has been in the regular Army for twenty-eight years, he still retains his membership in the Indiana State Medical Association. He has now assumed command of the Winter General Hospital, at Topeka, Kansas.

Major Dale D. Dickson, of Letts, is on a research assignment concerning aero-medical training. The work is being done at the Muroc Army Air Field, Muroc, California. He was formerly stationed at Clovis, New Mexico.

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Captain William M. Sholty, of Lafayette, is chief of anesthesia for the 104th Evacuation Hospital. He writes, "I have enjoyed my work and it has been a grand experience for me. We are rather proud of our hospital. It is one of two hospitals in the Third Army to receive the unit plaque for meritorious service."

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The Bronze Star has been awarded to Major Henry J. Faul, of Evansville, for fulfilling the needs for medical support and lessening the burden of overcrowding in the division clearing stations. The citation reads, "His unusual skill as commander enabled his unit to admit a large number of battle casualties and to perform innumerable operations with a low mortality rate. His diligence and industrious attention to duty were instrumental in saving the lives of many troops, and in adding to the physical well-being of hundreds of others."

In command of Unit No. 2 of the Thirteenth Field Hospital, which was the first to operate on the Normandy beachhead, Major Faul has also received three bronze service stars, representing the battles of Northern Normandy, France and Belgium, and Germany No. 1.

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Happy birthday to the "Fighting 69th"! Also congratulations upon the unique birthday announcement sent out by the members of their force, showing the "presents" they have given to their nation since their activation two years ago, with the Siegfried Line, Ehrenbreitstein, and Leipzig all wrapped up in attractive ribbon-trimmed packages.

The 69th Division was the first to link with the Russians at the Elbe River. Their achievements are summed up in the following quotation taken from their announcement: "This was the fitting climax . . . Cracking the Siegfried Line . . . that was the beginning. Spanning the Rhine, storming Fort Ehrenbreitstein . . . triumphs that accelerated the pace. Then, spearheading the campaign through the stubborn towns and villages of central Germany . . . the battle-scarred road to the hardest-won victory—the conquest of Leipzig. Reaching beyond conquered Leipzig, the clenched fist opening wide to clasp the outstretched hand of the Red Army." The announcement said, "May 15th is our second anniversary, but the gifts are on us."

A copy of this announcement was sent to us by our Captain Claude J. Heritier, of Columbia City, who is on duty with the 724th Field Artillery Battalion.

Last, but not least, congratulations to all of you who brought Victory in Europe!

The Silver Star has been awarded to Major N. W. Hatfield, of Indianapolis, for remaining on duty and treating wounded soldiers for thirty-six hours after suffering a shrapnel wound in his leg. He was wounded on Biak Island. Major Hatfield was recently promoted from the rank of captain.

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From Bad Mergentheim, Germany, Captain Charles F. Gillespie, of Indianapolis, who is stationed with the 116th Evacuation Hospital, wrote: "Our hospital is now operating along station hospital lines, but we still evacuate a fair percentage. More of our patients are returning direct to duty than formerly, however. Up until May second we followed the troops, taking care of battle casualties, but on that date we moved into Dachau to care for the unlucky inhabitants of that infamous concentration camp. We took care of about two thousand typhus cases there in a month. I have some good 'horror' or 'atrocity' pictures to show when I return. Incidentally, our unit knows nothing as yet about our ultimate disposition.

"Recently I made a Sunday trip to Heidelburg. It was my first visit. The old schloss was extremely interesting, but the university was surprisingly small. The place where the episodes of 'The Student Prince' occurred was also rather unimposing in appearance.

"I am enjoying my stay at this German spa, but Indiana would seem a hundred times better!"

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The St. Joseph County Medical Society *Bulletin* has published a letter from Captain James W. Ward, of South Bend, which came from France and which is very interesting, and which we wish to quote herewith:

"I just came back from a walk across the river. There were a lot of people out. Guess it is their day to do some shopping. They are all mixed up, as some take Saturday afternoon off and others do not open their stores on Monday. All take two or three hours off at noon. No one has much to sell at any time. Jerry took about everything good before he left, leaving the stores with little to sell.

"I visited Colmar and enjoyed it. It was a big holiday in that the five-star French general was visiting, and everybody was happy over their liberation. The city didn't seem to be shot up much, although we did see some villages and towns in which every house was destroyed. Those houses that our bombers and artillery didn't get must have been destroyed by the Jerries so that no housing facilities would be available to our advancing troops. At Colmar some of the Alsatian girls were in native costume or holiday (party) attire—quite colorful and rather attractive. We saw a group of collaborators who were a sour-looking bunch—pretty grim-faced and serious. Quite a crowd were watching the humiliation of a couple of high moguls (Jerries) who were under guard and were using shovels to fill in some bomb craters or mine holes. All in all it was very interesting."

# News Notes

Dr. George W. Dewey, of Pine Village, has been appointed post surgeon of the Indiana State Soldiers Home, at Lafayette. He will take up his duties there July first.

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Dr. Willard A. VanNest will resume his practice of medicine and surgery in Ashley after an absence of fifteen months, during which time he has been in Toledo, Ohio.

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The Indiana Tuberculosis Association, at its meeting in Indianapolis on May ninth, elected Dr. John A. Davis, of Flat Rock, as president, succeeding Dr. James F. Spigler, of Terre Haute.

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We are pleased to report that Dr. Thomas C. Haller, of Williamsport, was elected to membership in the International College of Surgeons at the regular meeting of the Executive Committee of the United States Chapter, held at Knoxville, Tennessee, on June ninth.

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Dr. George W. Boner, formerly head of the medical department of the Muscatatuck State School at Butlerville, has accepted the appointment as superintendent of the Madison State Hospital. He succeeds Dr. L. E. Pennington, who resigned to become superintendent of a state institution in Georgia.

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Governor Ralph Gates has appointed Dr. Renos H. Richards, of Patricksburg, as a member of the State Board of Beauty Culturist Examiners for a four-year term. At a meeting of the board in June, Doctor Richards was elected president.

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Dr. E. H. Clauser, of Muncie, has been appointed by Governor Gates as chairman of the Indiana State Board of Health hospital regulating and licensing council. The council was created by the last General Assembly.

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Lieutenant Colonel Joseph E. Walther, of Rushville, and Miss Mary Margaret Ruddell, of Indianapolis, were married July tenth at the home of the bride's parents, Dr. and Mrs. Karl R. Ruddell. Colonel Walther was a graduate of Indiana University School of Medicine in 1936, and Mrs. Walther is a graduate of Butler University and has received her master's degree in fine arts from Columbia University. After three months postgraduate training at the University of Minnesota, Colonel Walther will be assigned to the Office of the Air Surgeon, Washington, D. C.

Dr. Lyman R. Pearson, of Indianapolis, who formed a partnership with Dr. Homer H. Wheeler before his recent death, has taken over the office and records of Dr. Wheeler, and will continue his practice of colo-proctology.

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Dr. E. T. Edwards and Miss Mary Jane Decker, both of Vincennes, were married June thirtieth at the First Methodist Church, at Vincennes. Doctor Edwards is a graduate of the Indiana University School of Medicine, and Mrs. Edwards is a graduate of Indiana University.

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It has been announced that Dr. Anderson Nettleship has been appointed as director of the pathological department of the Fort Wayne Medical Laboratory and the laboratories of the Methodist and Lutheran Hospitals in Fort Wayne. Doctor Nettleship was formerly the pathologist at the Indianapolis City Hospital, and associate pathologist at the Indiana University School of Medicine.

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Under the direction of the City Board of Health, the construction of a health center building as an adjunct to Flanner House was begun on June thirteenth. The building will cost approximately $105,000, with an additional $20,000 to be spent for equipment, and will contain clinic, examination and x-ray rooms and offices for staff members. The work will be aligned with the city's slum clearance project, and in addition to diagnosis of the causes, particularly from the standpoint of housing and environment, a case-finding program of tuberculosis, venereal diseases, pre-natal medicine, infant and child health, dental, and general medicine will be conducted.

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### MEDICO-LEGAL CONFERENCE AND SEMINAR

The Department of Legal Medicine of the medical schools of Harvard, Tufts, and Boston University in association with the Massachusetts Medico-Legal Society will hold its fourth annual seminar October 1 to 6, inclusive, at Boston, Massachusetts, and will present a six-day program of lectures, conferences, and demonstrations having to do with the investigation of deaths in the interest of public safety. Attendance during five of the six days of the course will be limited to fifteen persons who have registered in advance. On one day (October 3) the program will be open to any physician, lawyer, police official, or senior medical student who may care to attend.

Further information may be obtained from the secretary of the Massachusetts Medico-Legal Society, 25 Shattuck Street, Boston.

Dr. Charles C. Crampton, of Delphi, who has been practicing medicine in this city for fifty-two years, except for the time he spent in the service during the first World War, recently attended the fifty-second anniversary of his graduating class at the University of Louisville.

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The Board of Trustees of the Culver Hospital has announced the opening of the Shapera Memorial Medical Library, made possible by a substantial gift given by Mr. Morris Shapera, of Crawfordsville, for the establishment of such a library. During the past year the library has been stocked with books and periodicals, and, it is stated, will now compare favorably with many libraries in the larger Indiana hospitals.

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After three years service in the Navy, Dr. Harvey V. Scott has returned to Fort Wayne, and has reopened his office in the Duemling Clinic for the practice of pediatrics. For the first eighteen months Doctor Scott was stationed at the Naval Dispensary in Washington, D. C., caring for veterans and their families. He then was sent to sea aboard an attack transport, and upon arriving in England learned that he was to participate in the Normandy invasion. After hard work caring for the wounded as they returned from the beachheads the medical officers were returned to England, but soon were sent out again for the invasion of Southern France. After that Doctor Scott took a sight-seeing tour of Rome, Naples, the Isle of Capri, Biserte, Ireland, and Scotland. He flew home by way of Newfoundland.

Dr. Howard J. Henry and Miss Lena M. Edwards, both of Indianapolis, were married on June first at the North Methodist Church, at Indianapolis. Dr. and Mrs. Henry will reside in Indianapolis, where Doctor Henry is an intern at the City Hospital.

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After thirty-eight months' service as a captain in the Third Air Force, Dr. William A. Kemp has been placed on inactive status and has reopened his office in Connersville for the practice of medicine. Doctor Kemp was last stationed at Key Field, Meridian, Mississippi, where he was chief of the surgical section at the base hospital.

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Major Lowell C. Smith has retired from active service in the Army Medical Corps and is now at his home in Lafayette. For the past several months he has been stationed at the Fletcher General Hospital, at Cambridge, Ohio. Prior to that he served in the European Theatre for six months.

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Dr. Harold P. Graessle, of Seymour, is to be congratulated upon being the first recipient of the Seymour Distinguished Service Award, a Rotary plaque engraved with the name of the recipient and a scroll signed by the president and secretary of the Rotary Club. According to the award qualifications, "The award shall be, in the fullest sense, a recognition of the highest type of altruistic public service and in keeping with the ideals and objects of Rotary," and shall be presented for service rendered within the past eighteen months, and which will have a lasting influence in the field of local service at Seymour.

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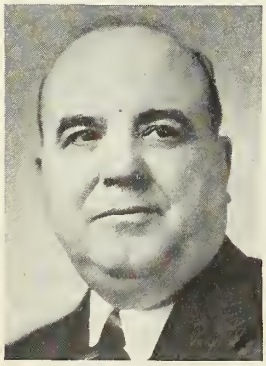
Announcement has been made by Governor Ralph F. Gates of the appointment of Dr. J. T. Oliphant, of Farmersburg; Dr. James L. Wyatt, of Fort Wayne; and Dr. David R. Johns, of East Chicago, as members of the Indiana State Board of Health. All three physicians will serve four-year terms. Doctor Johns has been named chairman of the board. Membership of the board was reorganized by the last General Assembly. Under the new and expanded health law a provision is made for the research, investigation, and dissemination of knowledge concerning the health problems of middle and advanced age.

Doctor Oliphant is retiring president of the Indiana State Medical Association, Doctor Wyatt is immediate past president of the Fort Wayne (Allen County) Medical Society, and Doctor Johns is at present a member of the Committee on Industrial Health of the Indiana State Medical Association.



*David R. Johns, M.D.*

*J. T. Oliphant, M.D.*

*James L Wyatt, M.D.*

# Deaths

## DIED IN MILITARY SERVICE

**Captain Charles Dougherty Clark, M.D.**, Army of the United States, died on April twenty-eighth as the result of a Japanese suicide plane attack which crashed into the *U.S.S. Comfort*, naval hospital ship, fifty miles off Okinawa, killing most of the personnel at five surgical stations. Captain Clark had just completed an operation and was assisting in another operation at the time of his death. He is buried on Guam.

*Captain Charles D. Clark*

Captain Clark was thirty-five years of age. He was a graduate of the Wayne University College of Medicine, in Detroit, in 1939, and was a resident in surgery for two years at the Royal Oak Hospital, at Royal Oak, Michigan. In 1941 he became medical director of the Bendix Aviation Corporation, in South Bend, and remained there until his entry into the Army Medical Corps on July 1, 1942. He first served as Chief of Industrial Medicine and Surgery at the Huntsville Arsenal, Huntsville, Alabama, and was transferred from there to Camp Miles Standish, at Taunton, Massachusetts. He had served overseas for three months in Hawaii and Australia. He was then assigned to the *U.S.S. Comfort* as assistant chief of surgery. Because of his outstanding work, he had been recommended for promotion to major.

Captain Clark was a member of the St. Joseph County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**William B. Page, M.D.**, died suddenly on June fourteenth at his home in Goshen. He was seventy-four years of age. Dr. Page graduated from the Hering Medical College, in Chicago, in 1896.

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**Joseph P. Meyers, M.D.**, of Edinburg, died at his home on June tenth. Doctor Meyers was seventy years of age. He was a graduate of the Louisville Medical College, in 1898, and had been practicing medicine in Edinburg for forty-five years, retiring four years ago after becoming ill.

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**Donald A. Bartley, M.D.**, of Indianapolis, died on June sixteenth in a local hospital, after an illness of seven months. He was fifty-eight years of age. Doctor Bartley was a graduate of the Indiana University School of Medicine, and a practicing ophthalmologist in Indianapolis. At the time of his death he was assistant professor of Ophthalmology at the Indiana University School of Medicine. Doctor Bartley served as a captain in the British Medical Corps in World War I, and had done postgraduate work in Chicago, London and Paris, and was a member of the American Board of Ophthalmology. He was a member of the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and a Fellow of the American Medical Association.

**Charles Alonzo Brown, M.D.**, of Plymouth, died on June eighteenth at the age of eighty-three after an illness of several years. He was a graduate of the Homeopathic Medical College of Missouri, in St. Louis, in 1890, and had practiced in Plymouth until his retirement several years ago.

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**Homer H. Wheeler, M.D.**, of Indianapolis, died July third at a hospital in Philadelphia. He was seventy-three years of age. Doctor Wheeler was graduated from the Central College of Physicians and Surgeons, in Indianapolis, in 1897, after which he did postgraduate work in Europe and the United States. In World War I, Doctor Wheeler served as a captain in the Medical Corps. From 1907 until 1937 he was assistant professor of Surgery (Proctology) at the Indiana University School of Medicine. In 1926 he was vice-chairman of the Surgical Section of the Indiana State Medical Association, and served as a member of the Association's Executive Committee from 1933 inclusive of 1936. Doctor Wheeler was a member of the American Proctologic Society and the American College of Surgeons. He was also a member of the Indianapolis (Marion County) Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

**James H. Moroney, M.D.,** of Winchester, died at his home on July eighth, at the age of eighty-nine years. Doctor Morony was a graduate of the Starling Medical College, in Columbus, in 1885. He was a member of the Randolph County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**Cassell C. Tucker, M.D.,** of Greencastle, died on June sixth at the age of fifty-four. Doctor Tucker was a graduate of the Harvard Medical School, in Boston, in 1915, and had practiced in Greencastle since 1919. In World War I he served as a captain first with the British Medical Corps, and then transferred to the American Medical Corps when the United States entered the war. It was while serving with the British that Doctor Tucker was awarded the British Military Cross, by King George at Buckingham Palace. Doctor Tucker was a member of the Putnam County Medical Society, the Indiana State Medical Association, and a Fellow of the American Medical Association.

**Walter Nixon Thompson, M.D.,** of Sullivan, died on July seventeenth, at the age of eighty years. He had practiced in Sullivan for fifty-nine years. Doctor Thompson was a graduate of the Rush Medical College in 1886, and limited his practice to anesthesia. He was a member of the Sullivan County Medical Society and had in the past served several terms as its president. He was also an honorary member of the Indiana State Medical Association, and a Fellow of the American Medical Association.

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**Marvin A. McDowell, M.D.,** of Logansport, died on May twenty-first, at the age of sixty-six years, after an illness of three months. He graduated from the Indiana University School of Medicine, in Indianapolis, in 1911. During World War I he served as a captain in the Army Medical Corps. Doctor McDowell was a practicing physician in Peru for a number of years before becoming a member of the medical staff at the Logansport State Hospital, where he served for sixteen years. He was a member of the Cass County Medical Society, the Indiana State Medical Association, the American Psychiatric Association, and a Fellow of the American Medical Association.

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## INDIANA STATE BOARD OF HEALTH

### DIVISION OF COMMUNICABLE DISEASE CONTROL

**Monthly Report, May, 1945**

| *Diseases* | *May 1945* | *April 1945* | *March 1945* | *May 1944* | *May 1943* |
|---|---|---|---|---|---|
| Chickenpox | 219 | 257 | 529 | 371 | 370 |
| Measles | 157 | 106 | 142 | 576 | 2248 |
| Scarlet Fever | 403 | 451 | 782 | 561 | 302 |
| Smallpox | 10 | 7 | 10 | 8 | 7 |
| Typhoid Fever | 3 | 10 | 10 | 9 | 8 |
| Whooping Cough | 72 | 43 | 60 | 46 | 320 |
| Diphtheria | 17 | 16 | 39 | 17 | 23 |
| Influenza | 26 | 4 | 54 | 6 | 39 |
| Pneumonia | 9 | 11 | 23 | 5 | 70 |
| Mumps | 237 | 280 | 456 | 208 | 483 |
| Poliomyelitis | 4 | 0 | 2 | 1 | 1 |
| Cerebrospinal Meningitis | 12 | 14 | 19 | 23 | 34 |
| Nonepidemic Meningitis | 2 | 1 | 0 | 1 | 0 |
| Trachoma | 1 | 2 | 0 | 1 | 0 |
| Septic Sore Throat | 1 | 8 | 6 | 1 | 2 |
| Impetigo | 2 | 3 | 0 | 2 | 0 |
| Dysentery, Unclassified | 2 | 0 | 0 | 1 | 0 |
| Erysipelas | 1 | 3 | 1 | 0 | 0 |
| Undulant Fever | 3 | 4 | 1 | 3 | 8 |
| Rubella | 8 | 8 | 9 | 10 | 320 |
| Tetanus | 2 | 1 | 0 | 1 | 0 |
| Vincent's Angina | 2 | 0 | 0 | 1 | 0 |
| Rocky Mt. Spotted Fever | 2 | 0 | 0 | 0 | 0 |
| Malaria— | | | | | |
| Acquired inside U. S. | 1 | 0 | 0 | 0 | * 2 |
| Tuberculosis, Pulmonary | 167 | 259 | 426 | 137 | 328 |
| Tuberculosis, other forms | 10 | 7 | 10 | 3 | 97 |

* Not classified as to whether the malaria was acquired inside or outside of the United States.

The way to insure your future is by buying United States War Bonds.

## INDIANA STATE BOARD OF HEALTH

### DIVISION OF COMMUNICABLE DISEASE CONTROL

**Monthly Report—June, 1945**

| *Diseases* | *June 1945* | *May 1945* | *April 1945* | *June 1944* | *June 1943* |
|---|---|---|---|---|---|
| Chickenpox | 162 | 219 | 257 | 182 | 150 |
| Measles | 145 | 157 | 106 | 275 | 1,133 |
| Scarlet Fever | 219 | 403 | 451 | 192 | 131 |
| Smallpox | 1 | 10 | 7 | 0 | 5 |
| Typhoid Fever | 10 | 3 | 10 | 3 | 9 |
| Whooping Cough | 103 | 72 | 43 | 74 | 248 |
| Diphtheria | 24 | 17 | 16 | 13 | 13 |
| Influenza | 23 | 26 | 4 | 4 | 6 |
| Pneumonia | 6 | 9 | 11 | 4 | 25 |
| Mumps | 186 | 237 | 280 | 199 | 110 |
| Poliomyelitis | 7 | 4 | 0 | 1 | 1 |
| Amebic Dysentery | 1 | 0 | 0 | 1 | 0 |
| Cerebro-Spinal Meningitis | 7 | 12 | 14 | 18 | 23 |
| Meningitis, Nonepidemic | 1 | 2 | 1 | 0 | 0 |
| Tetanus | 1 | 2 | 1 | 0 | 2 |
| Trachoma | 1 | 1 | 2 | 1 | 0 |
| Rocky Mt. Spotted Fever | 6 | 2 | 0 | 0 | 2 |
| Tularemia | 1 | 0 | 0 | 0 | 0 |
| Septic Sore Throat | 1 | 1 | 8 | 0 | 0 |
| Undulant Fever | 4 | 3 | 4 | 10 | 6 |
| Impetigo | 5 | 2 | 3 | 0 | 0 |
| Silicosis | 1 | 0 | 1 | 0 | 0 |
| Erysipelas | 2 | 1 | 3 | 0 | 1 |
| Rubella | 6 | 8 | 8 | 12 | 65 |
| Conjunctivitis | 1 | 0 | 0 | 0 | 0 |
| Infectious Jaundice | 5 | 0 | 3 | 0 | 0 |
| Malaria — Acquired Outside United States | 3 | 1 | 1 | 3* | 1* |
| Tuberculosis, Pulmonary | 285 | 167 | 259 | 519 | 235 |
| Tuberculosis, Other Forms | 12 | 10 | 7 | 2 | 29 |

** Not classified as to whether the malaria was acquired inside or outside of the United States.*

*(Continued on page xxii)*

*(Continued from page 288)*

# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION

### EXECUTIVE COMMITTEE

June 17, 1945

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; N. K. Forster, M.D.; F. T. Romberger, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney; T. A. Hendricks, executive secretary, and Ray E. Smith, assistant executive secretary.

Report made that Dr. J. E. Ferrell, president-elect, is in the Methodist Hospital, Indianapolis, convalescing from an operation.

**Membership Report**

| | |
|---|---|
| Number of members June 16, 1945 | 3,228* |
| Number of members June 16, 1944 | 3,182 |
| Gain over last year | 46 |
| Number of members Dec. 31, 1944 | 3,400 |

* Includes 973 in military service and 140 honorary members.

**Headquarters' Office**

Report made that Mr. Ray E. Smith is acting as assistant executive secretary to the association on a part-time basis, starting June 1.

Statements of receipts and expenditures for April and May for the association committees and THE JOURNAL were approved.

**1945 Annual Session, French Lick, Tuesday, Wednesday, and Thursday, October 2, 3, and 4, 1945**

The committee decided that arrangements should proceed for holding the annual meeting just as if there was no question in regard to having such a session. A reappraisal of the situation will be made at the next meeting of the Executive Committee. At any rate, plans are to be made to have the September issue of THE JOURNAL the annual meeting issue, with committee reports.

If the regular annual meeting is canceled, the committee approved the transfer of the meeting of the House of Delegates from French Lick to Indianapolis.

**Legislative, Legal, and Social Security Matters**

**National**

Wagner-Murray-Dingell bills, S. 1050 and H.R. 3293, introduced.

Letter received from Senator Wagner in regard to S. 1050. A copy of Senator Wagner's original letter, together with an aswer from the Executive Committee, is to be published in THE JOURNAL.

Letter received from National Lawyers Guild in favor of the Wagner-Murray-Dingell Bill. It is understood that the American Bar Association, which opposed the 1943 Wagner-Murray-Dingell Bill, is equally opposed to the present bill. Report made that the Council on Medical Service and Public Relations, of the American Medical Association, is to hold a joint meeting with the Board of Trustees of the American Medical Association on June 20, 21, and 22. Statement may be expected from the Council in regard to the bill, and a positive program on the part of the American Medical Association may be anticipated.

*Farm Bureau activities.* Letter received from Dr. F. S. Crockett, of Lafayette, that the Farm Bureau is interested in a health program in rural communities. Dr. Crockett has forwarded this information to the American Medical Association.

**Local**

Copy of a letter received by an Indiana state senator from a chiropractor, complaining of the action taken by the Senate in killing the chiropractic bill, brought to the attention of the committee. The committee felt that the senator should be congratulated upon his reply to the chiropractor, which, in the opinion of the committee, was


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#### Prepayment Medical Plans

*Report on progress, by W. U. Kennedy, M.D.* (See minutes of luncheon meeting.)

Letters received from the following accepting appointments as laymen to sit in with the Committee on Prepayment of Medical and Surgical Care to formulate a prepayment medical plan for Indiana:

Mr. Jack Rosebrough, acting manager of Hoosier Farm Bureau Life Insurance Company, to represent the Indiana Farm Bureau.

Mr. John Acker, secretary-treasurer of Indiana State Federation of Labor.

Mrs. Don Datisman, 129 W. 43rd Street, Gary, Indiana, to represent the Indiana League of Women Voters.

So far the CIO and the State Chamber of Commerce have not been heard from.

Letter received from Dr. Robert Kelsey, of LaPorte, stating that the Indiana Farm Bureau is selling a health policy in Elkhart County on an indemnity basis. The letter stated that the Farm Bureau is selling policies in fifty-two counties of the state.

Statement made at the committee meeting that the CIO had obtained a charter for its own medical care organization.

#### Organization Matters

Letters have been written by Dr. Forster to chairmen of key committees, suggesting a program of action. The Executive Committee suggested that a copy of each of these letters be made and sent to each member of the Executive Committee and to members of the Council.

The committee moved to drop the membership of the Indiana State Medical Association in the American Public Health Association.

#### State Board of Medical Registration and Examination and Cult Practice

The Executive Committee went on record recommending to the House of Delegates that a bill be presented at the next session of the General Assembly, providing for an adequate annual registration fee. This motion was made by Dr. Forster, seconded by Dr. Romberger.

#### War and Postwar Medicine

*County survey.* A county survey requested by the Bureau of Information of the American Medical Association has been completed for seventy-six counties in Indiana.

Letter received from Lieutenant Colonel Robert D. Bickel, director of the Bureau of Information of the American Medical Association, stating that the bureau had adopted nationally the system of reporting changes that had been used in Indiana.

Report received by the committee from Dr. Charles R. Bird, chairman of Procurement and Assignment Service for Indiana, in regard to the meeting that was held recently in the Governor's Office of the newly-created Bureau on Veterans' Affairs. The committee expressed its appreciation of the work being done by Dr. Bird, and suggested that this entire matter be left with Dr. Bird and the War Participation Committee.

The Executive Committee went on record that the state medical asociation should prepare a letter to be presented at the luncheon meeting in regard to the speedy return of men in service who are not necessary to the armed forces. This motion was made by Dr. Romberger, seconded by Dr. Forster, and Mr. Stump was appointed to draft this letter.

Dr. McCaskey reported upon a recent trip to Washington in regard to the protest of the physicians in service being assigned to the Veterans' Bureau, in regard to the number of doctors who might be released from the armed forces, and in regard to the plan to fill junior and senior residencies with doctors who have been in service.

#### Medical Education

Dr. Nafe called the attention of the committee to the fact that he felt that the Indiana State Medical Association should approve in some way the movement which is under foot to bring the first year of medicine to the medical school in Indianapolis rather than having it continued at Bloomington.. He stated that he was informed that in only two states is the medical course divided as it is in Indiana at the present time. In answer to the question as to whether present facilities at the medical center would take care of this added student population, he stated that it would probably necessitate the construction of a new building on the Indianapolis campus. The Executive Committee felt that this is a matter that should be referred to the Committee on Medical Education.

#### Physical Restoration Service

In a note to the Executive Committee, Dr. Norman Beatty reported that he objected to certain statements contained in the outline for physical restoration service that is being undertaken by the state committee in charge. The committee suggested that Dr. Beatty should be invited to the next Executive Committee meeting to amplify and discuss this matter.

#### The Journal

The reaction to THE JOURNAL's increase in advertising rates has been favorable.

The Executive Committee recommended that THE JOURNAL be listed in *Standard Rate and Data* as an individual journal, and not merely as a member of the cooperative group of state medical journals.

Report made that reprints are now available.

Report made that The Maltine Company advertisement was not acceptable due to the fact that the wording of the advertisement did not conform with the advertising principles of the American Medical Association.

Tom Joyce Seven-Up advertising canceled.

Report made that the Hoosier Farm Bureau article would be published in the July issue of THE JOURNAL.

Report on JOURNAL finances made by Dr. Weyerbacher.

There being no further business, the meeting was adjourned.

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## LUNCHEON MEETING OF THE EXECUTIVE COMMITTEE

June 17, 1945.

The Executive Committee held a luncheon meeting with the following committees and representatives of the Indiana State Medical Association:

*Executive Committee:*

*C. A. Nafe, Indianapolis, chairman
*C. H. McCaskey, Indianapolis
*N. K. Forster, Hammond, president
J. E. Ferrell, Fortville, president-elect
*F. T. Romberger, Lafayette, chairman of Council
E. M. Shanklin, Hammond, editor of THE JOURNAL
*A. F. Weyerbacher, Indianapolis, treasurer
*Albert Stump, Indianapolis, attorney
*Thomas A. Hendricks, executive secretary
*Ray E. Smith, assistant executive secretary

*Drafting Panel Committee:*

*N. K. Forster, Hammond, chairman
*J. William Wright, Indianapolis
*J. T. Oliphant, Farmersburg
H. G. Hamer, Indianapolis
*F. T. Romberger, Lafayette
J. E. Ferrell, Fortville
*C. H. McCaskey, Indianapolis

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# SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

*Delegates and Alternates to the A. M. A.:*

*Don F. Cameron, Fort Wayne,delegate
*F. S. Crockett, Lafayette, delegate
H. G. Hamer, Indianapolis, Delegate
George R. Dillinger, French Lick, delegate
Norman M. Beatty, Indianapolis, alternate
*A. M. Mitchell, Terre Haute, alternate
Karl R. Ruddell, Indianapolis, alternate
A. S. Giordano, South Bend, alternate

*Bureau of Publicity:*

H. G. Hamer, Indianapolis, chairman
Karl R. Ruddell, Indianapolis
Ben B. Moore,Indianapolis
*Mrs. C. S. Stewart, Indianapolis

*Committee on Public Policy and Legislation:*

Norman M. Beatty, Indianapolis, co-chairman
*J. William Wright, Indianapolis, co-chairman

*Committee on Prepayment of Medical and Surgical Care:*

*W. U. Kennedy, New Castle, chairman

*Committee on Postwar Medical Service:*

*John D. VanNuys, Indianapolis, chairman
*William C. Wright, Fort Wayne
O. R. Spigler, Terre Haute
Paul W. Ferry, Kokomo
R. N. Bills, Gary
*W. R. Davidson, Evansville
Robert V. Hoffman, South Bend
S. T. Miller, Elkhart
R. W. Lavengood, Marion

*Indiana State Board of Health:*

*Colonel Leroy E. Burney, Indianapolis, secretary
*Thurman B. Rice, Indianapolis
* *Those so marked were present.*

Dr. VanNuys made a short report on the activities of the Committee on Postwar Medical Service, which held a meeting prior to the luncheon.

Dr. Thurman B. Rice introduced Colonel Leroy E. Burney, Indianapolis, the new secretary of the Indiana State Board of Health.

Dr. Forster reported upon the Drafting Panel Committee which was created as a result of the meeting of seventeen state medical society presidents, at Detroit, at the invitation of the Michigan State Medical Society. The group present took the following action:

(1) That the Drafting Panel Committee draw up a program to be presented at the next meeting of the seventeen state presidents.

(2) That only the House of Delegates could vote the necesary funds to take part in the radio hookup suggested at the Michigan meeting. The Indiana State Medical Association's share of this cost would be about $3,000.00 for the series of thirteen fifteen-minute broadcasts.

(3) Under the direction of the Bureau of Publicity, Mrs. C. S. Stewart is to make an immediate survey as to how much a state hookup would cost for a series of Indiana broadcasts.

Dr. W. U. Kennedy, chairman of the Committee on Prepayment of Medical and Surgical Care, reported upon the activities of this committee.

## LOCAL SOCIETY REPORTS

**Elkhart County Medical Society** members entertained members of the Auxiliary at a dinner meeting in Elkhart on May twenty-second. Following the dinner an address was given by Dr. Waldemar Vestergaard, Scandinavian scientist. The program also included entertainment by a comedian from Chicago. Approximately sixty members attended the meeting.

* * *

**Montgomery County Medical Society** members held a meeting on June twenty-first at the Culver Hospital, in Crawfordsville. The guest speaker was Dr. Clyde G. Culbertson, director of the Laboratories of the Indiana State Board of Health and of the Indiana University Medical Center, Indianapolis, whose subject was "Tropical Diseases Indigenous to Indiana." Thirteen members were present.

* * *

**Putnam County Medical Society** members held their last spring meeting on June fourteenth, in Greencastle. Six members and one guest were present.

* * *

**Warrick County Medical Society** members held a business meeting in the office of the county nurse, in Boonville, on June twelfth.

## COUNCILOR REPORT

### FOURTH COUNCILOR DISTRICT MEETING

The forty-first annual meeting of the Fourth Councilor District of the Indiana State Medical Association was held at the Clifty Falls State Park on May twenty-third. Luncheon was held at noon for the delegates, while the visiting ladies were entertained at the home of Dr. and Mrs. George A. May. Lieutenant Colonel Truman G. Blocker, of Wakeman General Hospital, Camp Atterbury, discussed problems of plastic surgery in the armed forces; Dr. Kenneth G. Kohlstaedt, of the Indianapolis City Hospital, discussed hypertension; and Major Herman Selinski, of Wakeman General Hospital, discussed psychiatric casualties of World War II, followed by a discussion and question period.

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A HALF CENTURY of warfare against typhoid fever has made the disease almost a curiosity. Filtration plants and chlorination, together with scientific disposal of sewage and garbage, are formidable sanitary barriers. Yet now and again these barriers are breached. Wherever hazards exist, those exposed should be vaccinated. The results obtained from compulsory vaccination in the armed forces of the United States have established the efficacy of the procedure.

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## *WOMAN'S AUXILIARY to the Indiana State Medical Association*

**President—Mrs. F. M. Gastineau, Indianapolis**
**President-elect—Mrs. S. J. Petronella, East Chicago**
**Corresponding Secretary—Mrs. C. L. Bock, Indianapolis**
**Treasurer—Mrs. A. W. Ratcliffe, Evansville**
**Press and Publicity—Mrs. A. B. Richter, Indianapolis**

### ALLEN

The sixth anniversary of the Allen County Auxiliary was celebrated at the Indian Village Pavilion on May first. A picnic supper was enjoyed. Following the election of officers, Mrs. E. N. Mendenhall talked on the "History of the Medical Auxiliary," and seven members presented a comedy skit.

### DELAWARE-BLACKFORD

On May sixteenth the Delaware-Blackford Auxiliary met at the home of Mrs. J. C. Silvers for a dinner meeting. Election of officers was held. Twenty-four members were present.

### LAKE

Mrs. J. W. Mather was hostess to the members of the Lake County Medical Auxiliary on April twelfth. The meeting was addressed by Dr. J. Robert Doty. Officers were elected.

A bridge-luncheon was held by the Gary and South Branches at the Sedan Tea Room on April twenty-fourth. Mrs. C. H. Bendler was installed as president.

### MARION

The Auxiliary to the Marion County Medical Society met on May fourth at the Women's Department Club for luncheon. Following the election of officers and the reading of annual reports, bridge was played.

### MARSHALL

Five members of the Marshall County Auxiliary were entertained at a luncheon at the home of Mrs. M. O. Klinger on May second.

### PORTER

A dinner meeting was held at the Hotel Lembke, on April twenty-fourth, by the members of the Porter County Medical Auxiliary.

### ST. JOSEPH

Mrs. M. D. Wygant was elected president of the Woman's Auxiliary to the St. Joseph County Medical Society at a meeting held May fourth at the home of Mrs. George F. Green.

### VANDERBURG

Dr. Caroline Goodwin, head of the Indianapolis Maternal Health Clinic, spoke at a luncheon meeting of the Vanderburg Auxiliary on April tenth. Guests included the members of the Maternal Health League, and members of the former League of Women Voters. Preceding the luncheon a business meeting was held.

At the May meeting Mrs. A. B. Hollander, a member of the Shrine Crippled Children's Hospital Committee, told of the work done by this group in the St. Louis hospital.

### VIGO

On April twenty-third the members of the Vigo County Auxiliary met at the Student Union Building. Mrs. C. R. LaBier was elected president for the next year.

Mrs. Harvey Decker was hostess to the May meeting of the auxiliary. A covered-dish luncheon was served. The program was a presentation of a modern farce in Shakespearean costume, "When Shakespeare's Ladies Meet." This was presented by the Sycamore Players.

# Books

## BOOKS RECEIVED

**THE MANAGEMENT OF OBSTETRIC DIFFICULTIES.** (Third Edition.) By Paul Titus, M.D., Secretary of the American Board of Obstetrics and Gynecology; Commander (MC) USNR, attached to Professional Division, Bureau of Medicine and Surgery, Navy Department, Washington, D.C. 1000 pages with 434 illustrations. Fabrikoid. Price $10.00. The C. V. Mosby Company, St. Louis, 1945.

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**HAYFEVER PLANTS.** Roger P. Wodehouse, Ph.D., Associate Director of Research in Allergy, Lederle Laboratories, Pearl River, New York. 245 pages with 72 illustrations. Price $4.75. Cloth. The Chronica Botanica Company, Waltham, Massachusetts, and the G. E. Stechert and Company, New York, 1945.

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## REVIEWED

**CLINICAL ROENTGENOLOGY OF THE DIGESTIVE TRACT.** (Second Edition.) By Maurice Feldman, M.D., Assistant Professor of Gastroenterology, University of Maryland. 769 pages with 551 illustrations. Cloth. Price $7.00. The Williams & Wilkins Company, Baltimore, 1945.

The second edition of this book covers every phase of Gastrointestinal Pathology. All of the new x-ray procedures have been added.

The book is made up in a logical sequence. It opens with a description of the normal esophagus, and then takes up the pathologic conditions of that organ.

The normal and pathologic stomach, duodenum, small intestine, colon, et cetera, are described in turn. The chapter on the small intestine is particularly interesting.

At the end of each different pathological condition described, there is a list of references appended, thus allowing the student to follow up any particular subject of interest. This is a great time-saver. The references are numerous, a large number of which are from foreign literature.

The book is valuable to the general practitioner and student. It is indispensable to the gastroenterologist and roentgenologist.

HENRI LECLAIRE, M.D.

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**AN INTRODUCTION TO MEDICAL MYCOLOGY.** Second Edition. By George M. Lewis, M.D., Assistant Professor of Clinical Medicine (Dermatology), Cornell University Medical School, and Mary E. Hopper, M.S., Research Fellow in Medicine, Cornell University Medical School. 342 pages with 77 illustrations. Cloth. Price, $6.50. The Year Book Publishers, Inc., 304 S. Dearborn Street, Chicago.

This is an excellent revision of the first edition of this book. A number of new features are added, one of which is a complete discussion of histoplasmosis.

As in the first edition, Part I takes up the Clinical, Theoretical, and Experimental Aspects of Fungus Diseases. Chapters on Immunity and Cutaneous Sensitization, Immune Bodies Circulating in the Blood, Fungus Diseases and Compensable Dermatoses are included, but the major portion of this section is devoted to complete discussions of the Superficial Mycoses and The Deep Mycoses with methods of diagnosis and treatment.

Part II presents Laboratory Methods, giving technics and descriptions of the morphology and cultural characteristics of the pathogenic fungi. In this section are also found chapters on Filtered Ultraviolet Radiation, Technic

of Passive Transfer Test, the Trichophytin Test and other Specific Skin Tests.

The many illustrations are excellent and should prove helpful to the inexperienced. Every section of each chapter has a good bibliography. The book would be a valuable addition to the library of the general practitioner or to those of specialists in a number of fields of medical work.

EDITH HAYNES, Ph.D.

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**MASS RADIOGRAPHY OF THE CHEST.** By Herman F. Hilliboe, M.D., Medical Director, Chief, Tuberculosis Control Division, United States Public Health Service, Washington, D.C.; and Russell H. Morgan, M.D., Surgeon (R), Medical Officer-in-Charge, Radiology Section, Tuberculosis Control Division, United States Public Health Service. 288 pages with 93 illustrations. Cloth. Price $3.50. The Year Book Publishers, Incorporated, Chicago, 1945.

The purpose of this book is to bring together information on "Mass Radiography" methods and knowledge, "and to assist those who contemplate work in this field." The book is of value to the public health worker, epidemiologist, and tuberculosis control officials. It would be of little value to the general practitioner or student.

The authors are well qualified by position and experience to write on this subject. They have great hopes for the future of photofluorography. The authors state, "It is hoped that soon all general hospitals will provide routine x-ray examination of the chest just as they are now making routine serologic tests for syphilis."

The book begins by giving a "History of Mass Radiography." "The Objectives of Tuberculosis Control" are next described. There is a good description of the equipment available.

The description of "X-ray Transformer Systems" is well done; however, one point is presented which will not be accepted by most radiologists. The statement is made that "both valve-rectified and self-rectified transformer systems are almost equally suitable" since "times do not impair radiographic quality." All of the radiographic equipment manufacturers are striving to build transformers and tubes that will cut down the time of exposure. It seems that radiographic quality would be influenced by motion in photofluorography as it is in ordinary photography and radiography.

The book closes by discussing the "Study and Care of Persons With Abnormal Films" and the "Future Development of Mass Radiography." The book is well indexed.

HENRI LECLAIRE, M.D.

**RADIO CALENDAR**

"YOUR HEALTH IN WARTIME"

Hear these broadcasts each week:

Indiana State Medical Association — Doctor Goodhealth—Monday, 2:00 P.M., WFBM, Indianapolis.

Vigo County Medical Society — Thursday, 12:15 P.M., WBOW, Terre Haute.

St. Joseph County Medical Society—Friday, 1:45 P.M., WSBT, South Bend.

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# THE JOURNAL

OF THE

# INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

*ISSUED MONTHLY under Direction of the Council*

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 38 SEPTEMBER, 1945 NUMBER 9


## TEMPORAL ARTERITIS


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INDIANAPOLIS


Arteritis of the temporal vessels was first described by Horton, Magath, and Brown[1] in 1934. At that time they described two cases, and came to the conclusion that this was an entity not previously described. Since 1934 approximately twenty-eight cases of temporal arteritis have been reported[2, 3, 4, 5, 6, 7, 8], and most authors have accepted this condition as a definite clinical syndrome. Although practically all of the cases have been reported in the United States, it does occur elsewhere. Three cases have been reported in England[3, 4], and one each in South America,[2] Canada,[7] and France.[5] Pathologically and clinically, all of these cases have been similar.

The probability of this disease occurring more often than is recognized prompts us to report the four cases that we have observed.

### CLINICAL MANIFESTATIONS

Temporal arteritis is a clinical syndrome that occurs more frequently in females than in males, and seems to be limited to elderly persons. All of the patients reported have been over fifty-five years of age.

The onset of the disease is characterized by more or less constant pain in the head, which tends to be more severe at night. This pain may be so severe as to require morphine for relief. The whole scalp may be tender, and the patient may have difficulty in finding a comfortable position when lying down. There is often an aggravation of the pain on chewing, sneezing, or coughing, and, as in one of our cases, the pain was so severe on mastication that it was thought by the patient that his dentures were at fault. Marked weakness, malaise, and sweats, which are usually worse at night, are prominent symptoms. There is fever—usually low, anorexia, weakness, weight loss, moderate leukocytosis, and secondary anemia. The patient appears subjectively much more ill than the objective findings would seem to indicate. Several days to four or five weeks after the onset of these symptoms the temporal arteries become prominent and sensitive, with inflamed, raised nodules along their course. With recovery the pulsation in these vessels disappears. The vessels become cord-like and finally non-palpable.

Other vessels have been observed to be involved.[9]

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Horton and Magath[2] observed involvement of a small branch of a radial artery and evidence of phlebitis in the retinal vein. Jennings[3] reported thrombosis of the retinal vessels. In one of our cases, in addition to the bilateral temporal arteritis there was an identical process in both posterior occipital arteries. Others[9, 10, 11] have reported cases in which there were changes in vision and varied ophthalmoscopic findings. One of our cases complained of dimness of vision without any ophthalmoscopic findings.

Various possible etiological agents have been suggested, such as focal infection, rheumatic infection, tuberculosis, and mycoses. Horton and Magath suggested that these changes in the arteries might be one of the "fruits of senility."[2] Up to this time no etiological agent has been demonstrated. Some authors[12] feel that arteritis of the temporal vessels is merely a common local manifestation of a generalized disease.

The disease generally runs a chronic course of four to twelve months duration, during which the patient may be in varying degrees of incapacitation. Some authors[13, 2, 14, 15, 16, 17] feel that removal of a segment of artery relieves the headache, although following this the fever and generalized symptoms may continue for an indefinite period. However, in two of our cases the operative site (following resection of a segment of artery) was more painful than before. This also was true in a case reported by Sprague and MacKenzie.[7]

There is no specific medication. Penicillin administered intramuscularly had no clinical effect on our last case.

In general, prognosis is good. Practically all cases have recovered, and it is the general belief that the disease is non-fatal. However, recently Chasnoff and Vorzimer[12] reported a case that died. In this case the arterial changes were widespread throughout the body, although they did not include a detailed autopsy report.

The pathological picture is characteristic, and is that of an inflammatory reaction. Briefly, there is a chronic periarteritis and arteritis. Thrombosis in the affected portion of the vessel is common. A detailed discussion of the pathological picture will be given in each of our reported cases.

## CASE REPORTS

*Case I.*

The first patient was a maiden lady, aged seventy-three, who was a life-long resident of a small village in Indiana. At the time she was seen in 1937 she complained of pain in the left ear and cramps in the legs. She stated that two weeks previously there had been severe pain over the right temporal region. This pain was severe enough to prevent sleep, and was made worse by mastication. Her appetite was poor, and she felt very languid. Family history revealed that her father and sister died of Bright's disease, a brother died of arteriosclerosis, and a sister and brother died of tuberculosis. The patient described herself as a "chronic complainer," and gave a history of having had frequent respiratory infections, and at the age of thirteen an illness suggesting rheumatic fever. In the past she had complained frequently of fatigue, soreness over joints, and attacks of numbness of the wrists and hands.

Physical examination showed a linear type, well-nourished lady who had a very pale complexion, white, silky hair, and blue eyes. There was marked tenderness over the right temporal artery, and along its course were small inflamed nodules. The oculi fundi were essentialy normal. There was a short, systolic blow heard over the apex of the heart. The blood pressure was 170/100. There was a lack of pulsation in the pedal vessels. A biopsy of the right temporal artery was done on November 16, 1937, by Dr. W. D. Gatch. The artery was closed and bloodless. The following day the patient complained of tenderness over both occipital arteries. On November 24, 1937, as much as possible of the left occipital artery was removed. Bleeding was encountered when this artery was sectioned. Exhaustive laboratory and clinical studies were made, all of which were negative except for a moderate hypochromic, microcytic anemia and a leukocytosis of approximately 14,000. Subsequently, the patient suffered marked weight loss due to a low intake of food because of pain on mastication and swallowing. She complained bitterly of inability to lie in a comfortable position because of pain in the scalp.

Exacerbation of pain continued until March, 1938, although no redness over the course of the vessels or fever were noted after November of 1937. Extreme weakness, easy fatigability, and sweating were present for nine months. She subsequently developed a mild Dupuytren's contracture. The operative wounds healed by first intention, leaving almost imperceptible scars. Two vessels involved were resected; two were not. Histological section of the temporal artery showed severe degeneration of the media with replacement by young connective tissue. The lumen itself was occluded by a mass of connective tissue and epithelioid cells.

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There were areas of irregular lymphocytic infiltration with scattered multinucleated giant cells and many eosinophils. The section of the left occipital artery showed a picture much more recent. Here a thrombus partially filled the lumen. The remaining lumen was filled with a rather thick layer of edematous young granulation tissue, throughout which were scattered many polymorphonuclear cells and eosinophils.

A prolonged search of a stained section did not reveal any tubercle bacilli. Cultures made from ground-up artery, and guinea-pig inoculation, were also negative for tubercle bacilli as well as mycotic organisms.

The patient is still living and well.

*Case II.*

The second patient, also a maiden lady seventy-four years of age, was a retired school teacher who had lived her entire life in a small village in central Indiana. She was of a linear type with a fair complexion, blue eyes, and white hair. She was seen on February 7, 1939, at which time she complained of pain in the temples and neck, radiating up behind the ears over the scalp, failing sight of two weeks' duration, weakness, nausea, poor appetite, and a bad taste in her mouth. The onset occurred in the last week of December, 1938, following a slight injury in which she struck her head against a chair. A day or so later she noticed painful cords in the right temporal region. These cords became so painful in the next two weeks that she sat in a chair to sleep in order to avoid the pain of lying down. She also noticed pain on mastication.

Her general health had been good except for scrofula at the age of twenty-one, complicated by poison ivy and erysipelas. Examination showed the temporal artery on the right to be cord-like and tortuous without pulsation. The tissues about it were swollen and very painful.

A few cervical lymph nodes, obviously calcified, were noted. Scars at the site of the previously-draining glands were seen on the left side of the neck. No signs of disease were found in the chest. The heart was negative except for a short systolic blow over the apex. Blood pressure was 170/80. There was a small amount of pitting edema about the ankles which quickly disappeared upon changing the patient from a sitting to a reclining posture. Examination of the oculi fundi was normal except for moderate arteriovenous compression.

A section of the right temporal artery was removed for histological examination. This patient's improvement was much more rapid than the first case. Except for a moderate anemia, exhaustive laboratory studies were negative. During her short hospital stay the patient's temperature never spiked over 100°.

The histological section showed the artery practically occluded by a granulomatous inflammatory process which involved all the coats. The significant histological features of this were the presence of epithelioid masses arranged in palisade fashion about the walls of the vessel. Numerous giant cells of the Langhans' type were seen with the occasional formation of a tubercle. Acid-fast stain showed rare typical acid-fast bacilli usually in the epithelioid cells. The pathological diagnosis was granulomatous arteritis with evidence strongly suggesting tuberculosis.

*Case III.*

This patient, a widow aged sixty-nine years, a resident of a small village, was admitted to the Robert Long Hospital in April, 1941, with a history of being awakened one night by severe pain in the mandible, radiating to the temples and occiput. She had the sensation that her jaws were locked and noticed hard "cords" in the temples. The pain subsided after two or three weeks, but the cords remained. She also noted pain in the right arm and shoulder, and on exercise pain in the legs, especially in the calf, which soon subsided on rest. She was aware of discomfort on mastication and sensitiveness to touch over the right side of the scalp.

In the past she had had many complaints consisting essentially of functional complaints regarding the gastrointestinal system. This led to an appendectomy years ago. At one time following bladder irritability with hematuria she was told that she had tuberculosis of the kidneys. At another time she was thought to have had pneumonia, which was a long time in resolving. In 1921 she had a rectal abscess which was said to be tuberculous, but this healed without resultant fistula. Her mother died of tuberculosis, and her father of cardiovascular disease.

Physical examination revealed a thin, somewhat pale woman not in apparent discomfort. The temporal arteries were represented by firm, cord-like structures. Along the course of the right artery there was a brownish desquamation and some tenderness. The fundi showed moderate arteriosclerosis. The lungs were clear to examination and x-ray study. The heart was slightly enlarged to the left. Blood pressure was 160/74. The pedal vessels did not pulsate and showed only slight oscillations on oscillometric examination. Complete study of the kidneys showed a slight, right hydronephrosis with no evidence of tuberculosis.

The patient's temperature did not become elevated over 100°. There was moderate hypochromic anemia with essentially normal white count. The sedimentation rate was increased. No biopsy of the temporal vessels was made. This patient made as satisfactory recovery and improved just as rapidly as those patients in which a section of artery had been removed.

*Case IV.*

The fourth patient was a married lady, aged sixty-nine, who had lived in a small village in Indiana all her life. She was admitted to the Robert Long Hospital in August, 1944, with a history of having had her teeth extracted about six months previously because of general ill health. Four or five weeks prior to admission the patient stated that she

had begun to have a temperature of 100° to 101°, which was associated with night sweats. At about the same time the sides of the face, forehead, and scalp became very sore and tender. She had difficulty in lying with her head on a pillow because of the pain it caused. Painful lumps appeared on the lateral sides of the forehead. Mastication was difficult and painful, and she attributed this to her newly-acquired dentures. These were removed, but the pain continued. There had been a marked weakness, loss of appetite, and a loss of fifteen pounds in weight in four weeks.

Examination showed a linear type individual with a fair complexion, blue eyes, and white hair. Blood pressure was 160/70. There were multiple small nodules along the course of the temporal arteries which were very painful to touch.

Extensive laboratory and clinical studies were negative with the exception of a moderate hypochromic microcytic anemia and a leukocytosis of 12,000. Sternal bone marrow study was done, which Dr. Clyde Culbertson reported as showing nodules of lymphoid tissue which was similar to that seen in early lymphatic, leukemic involvement of the bone marrow.

A biopsy performed on September 8, 1944, by Dr. William F. Montgomery, showed the artery to be about one-half occluded. Following this the patient experienced more pain than previously, and complained bitterly. However, her pain subsided gradually, and approximately six weeks later the pain had disappeared, but she continued to have fever and night sweats for six months after the onset. Now, nine months later, the patient still complains of some weakness and pain in the larger joints and back. Careful, frequent examination of the peripheral blood has not revealed any further evidence that the patient has a blood dyscrasia.

Histological section of the artery removed showed the adventitia to be infiltrated with numerous inflammatory cells which were deposited in between the muscle fibers and were destroying the muscle wall to a considerable extent. In the thickened subintimal layer there was marked vascularization with edematous, fibrous tissue containing numerous fibroblasts and in some cases giant cells. The adventitial blood vessels showed marked thickening and perivascular lymphocytic infiltration. Acid-fast stains were studied, but no acid-fast bacilli were found.

## COMMENTS

1. These four cases conform in all essential details to those originally described by Horton, Magath, and Brown.[1] These patients were all past sixty-nine years of age, all females, all of a linear, asthenic type, all of fair complexion with blue eyes and white hair, and all had moderate hypertension. The most prominent symptom was pain over the region of the temporal artery and scalp, which was made worse by mastication and lying down. There was a moderate low-grade fever, weight loss, weakness, sweating, and a protracted period of asthenia and various degrees of incapacitation. Vague, generalized joint pains and pain in the back were common symptoms during the protracted convalescence.

2. In all cases elaborate clinical studies failed to show any significant changes except a moderate leukocytosis and hypochromic anemia. In one case a sternal bone marrow study was done, which showed changes similar to those seen in lymphatic leukemia. However, this patient has been followed for a period of nine months and no evidence of leukemia has been demonstrated in the peripheral blood. In one case acid-fast stain showed rare but typical acid-fast bacilli in a section of artery removed.

3. The onset of the illness in one case suggested heart failure. The patient had been sitting up in a chair for two weeks because of the pain experienced on lying down, and had developed marked edema of the extremities. This edema disappeared when the patient changed from a sitting to a reclining posture. The onset in one other case was attributed to dentures which had been acquired recently. In a third case the onset had occurred following a slight injury to the head.

4. All of these patients were non-smokers.

5. In our four cases we had no evidence that resection of the involved artery was of any therapeutic value, as has been reported. In fact, two of the three patients who had a biopsy with a section of artery removed complained more bitterly of pain following this resection than before. Neither did they improve any more rapidly than the patient who did not have a section of the artery removed.

6. Low oscillometric readings in one case and absence of pedal pulsations in another suggest the possibility that the disease may be a generalized involvement of vessels other than the temporal vessels.

7. One of our cases complained of dimness of vision without any demonstrable ophthalmoscopic changes.

8. As far as we can determine, there has been no report of anyone else using penicillin in acute temporal arteritis. In our one case in which it was given intramuscularly, in a dosage of 20,000 units every four hours for a period of seven days, it apparently had no clinical effect.

## SUMMARY

1. We have reported four cases of acute temporal arteritis which conform to the syndrome as it has been reported in the literature.

2. Attention is called to certain features in our cases.

3. There is no specific therapy in acute temporal arteritis. Penicillin had no therapeutic effect in the one case in which it was tried.

The authors are deeply grateful to C. G. Culbertson, M.D., chief of the Clinical Pathological Laboratory, Indiana University Medical Center, for his assistance in the study of these cases.

# SOME ASPECTS OF CARDIOLOGY AS SEEN AT THE VETERANS ADMINISTRATION, INDIANAPOLIS, INDIANA*

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MEDICAL CORPS, ARMY OF THE UNITED STATES

The practice of cardiology as followed in a veterans hospital must, of necessity, present certain features relative to it which are peculiar to any such practice limited entirely to adult males, most of whom are in their forties. Thus, the degenerative forms of heart disease far predominate—coronary arteriosclerotic heart disease and hypertensive heart disease, either singly or in combination, comprising a total of 802 out of 1573 cases seen at the Veterans Administration, Indianapolis, Indiana, within the past four years, or more than fifty per cent of the total. But the interesting point is that a perusal of these cases discloses the fact that there is no form of heart disease which is not included in the list . Thus, there are four cases of congenital heart disease, forty-one cases of pulmonary hypertensive heart disease, fifty-six cases of syphilitic heart disease, twelve cases of metabolic heart disease—including one case of beriberi, forty-four cases of neurogenic heart disease, twenty-six cases of syphilitic disease of the aorta, ten cases of aortic aneurysm, one case of dissecting aneurysm of the aorta, not to mention well over one hundred cases of neurocirculatory asthenia. Not included in the above compilation are one case of ruptured arteriovenous aneurysm of the popliteal space, one case of luetic aneurysm involving both the arch of the aorta and the descending aorta with rupture and slow leakage from both aneurysmal sacs, one case of fibrinopurulent pericarditis in a case of staphylococcus septicémia, one case of tuberculous pericarditis and myocarditis with only minor involvement of the pulmonary structures and no other lesions elsewhere, and twelve cases of subacute bacterial endocarditis complicating other forms of heart disease. And, oh yes, one case of two coronary occlusions in a young male twenty-eight years old, one coronary occlusion in a male thirty-one years old, one case of mesenteric thrombosis in a severely decompensated cardiac with recovery on symptomatic treatment alone, and one case with strong evidence of three successive coronary occlusions. A brief account concerning some of the most interesting cases will be given later.

Of interest has been the changing trend noted in the past few years as veterans of World War II have begun to swell the hospital lists. Thus, while cases of degenerative heart disease have remained fairly constant, rheumatic heart disease has been on the increase, thirty-one cases having been seen in three thousand admissions in 1941, thirty-nine in 1942, forty-seven in 1943, and sixty-one in 1944—in each case with approximately the same number of total cases admitted to the hospital. Furthermore, the gamut has been run from the simple monocyclic variety with involvement of a few or several joints, with or without heart involvement, to the recurrent active or polycyclic type and the continuously active type (with continuous activity for a period of well over a year or more with either continuous peripheral signs of rheumatic activity but no heart lesions to the continuous type with severe and finally fatal heart damage, yet never manifesting any joint symptoms).

This writer recalls a case of a young adult, in his late twenties, with repeated flare-ups of rheumatic activity as manifested by sudden recurrence or sudden deepening of the signs of myocardial insufficiency, coupled with sudden rise in the sedimentation rate, leukocytosis, pulse rate, electrocardiographic changes, et cetera, for well over a year and with final demise in acute failure, yet never any manifestation of joint pathology. Our oldest individual with acute rheumatic fever with both fresh joint and cardiac involvement was a man of sixty-three in whom the diagnosis was proved later by autopsy when the veteran, who was fibrillating, developed a pulmonary infarct which softened, ruptured, and produced a spontaneous pneumothorax, which resulted in the patient's death despite repeated aspiration decompressions.

Similarly, of interest has been the realization that coronary occlusion is no longer a disease of other than young adults. Within the past few years many cases have been reported well under thirty of age, and we have seen several here below thirty-five. One case in particular comes to mind, that of a young man, seen in the out-patient clinic, aged twenty-eight, who had suffered one coronary occlusion while still in service—as conclusively proved by EKG, history, et cetera, and another shortly after his discharge—again proved conclusively—and who at time of examination was in failure but refused hospitalization because of a desire to get to work. Another case was thirty-one with a history of a coronary occlusion one year earlier, but with subsequent good recovery. On the other hand, we have been impressed, as have others, that the signs of frank coronary occlusion become fairly rare after the age of sixty. Furthermore, our mortality rate in recent coronary occlusions has decreased considerably since we have begun the routine employment of atropine sulfate, gr. 1/150 every four hours for the first week following the

* Presented before the Indianapolis (Marion County) Medical Society, at Indianapolis, on March 13, 1945.

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coronary insult, the rationale behind this therapeutic agent being that it overcomes the spasm in those coronary vessels other than the one infarcted, and which spasm following coronary occlusion, by adding still further to the anoxemia present, frequently causes the patient's death.

Malignant hypertension, too, has proved itself unusually common in this younger age group, with three young adults, all thirty years of age or less, with blood pressures ranging well over 220 systolic and 140 diastolic, and with typical neuroretinopathies, peripheral arteriosclerosis, et cetera, seen within the last year, with one of these men dying in uremia with complicating cardiac failure. A blood pressure of 180 systolic or more, and 100 or more diastolic, on repeated readings in young adults has been an everyday occurrence. Our experience with medical management in these cases has been very disappointing, the usual vasodilators (including thiocyanates), diet, sedatives, et cetera, having all proved of no avail. We have, however, been more and more impressed by the number of these cases in which a renal complication has been found by diligent search; for example, an intrarenal pelvis on one side with an atrophic kidney on the other, a history of renal colic many years before the onset of the hypertension with a non-functioning kidney filled with stones found now on investigation, an ectopic kidney or ureter on one side with renal damage on the other, an aberrant vessel with partial obstruction, et cetera. Unfortunately, most of our cases have first been seen when peripheral arteriosclerosis or heart damage is far advanced and surgery questionable. One case, however, who had suffered a coronary returned later for a pyelotomy following which his blood pressure, which had once more risen to 200/130, declined to 166/110, and remained so.

Pulmonary hypertensive heart disease has proved itself rather common here—at least four to five times the average given for figures for the entire country. In making the diagnosis, we are influenced by the history which must show pulmonary symptoms for a good many years before the cardiac manifestations appear, physical findings and x-ray evidence of severe pulmonary involvement, electrocardiographic changes of right heart strain, and the failure to explain the symptomatology adequately on other etiology. We believe that the explanation for the higher percentage of this type of case seen here rests in the occupational hazards involved—many of these men are from the southern part of the state, are coal miners, and have silicosis. Others have suffered for years from bronchial asthma or bronchiectasis. The need for a good test to determine pulmonary artery pressure is stressed here—it is badly needed.

Our experience with subacute bacterial endocarditis has been rather disappointing. In the past we have tried the sulfa drugs either alone or in combination with heparin or typhoid vaccine, or both, with no satisfactory results. Since the advent of penicillin we have had two cases of subacute bacterial endocarditis, one of which had a cerebral embolus shortly after the diagnosis was established and, despite penicillin, died; the other, a proved case of Streptococcus viridans superimposed on rheumatic mitral insufficiency and stenosis with low grade fever and symptoms of six months' duration, with two positive blood cultures (69 and 73 organisms per cc. blood, respectively) with petechiae and Osler's nodes. The second of these two cases was treated by penicillin and sulfadiazine with clearing of the blood stream, subsidence of all symptoms, and with the patient active and in good health eight months later. This we consider a case of remission.

Our experience with hyperthyroid heart disease here has been rather limited. Most of our cases of hyperthyroidism, for some unknown reason, have been either those of the early type with very little cardiac involvement, or those of hyperthyroidism in individuals with far-advanced cardiac pathology, as shown by hypertension, peripheral arteriosclerosis, cardiac enlargement, and signs of cardiac failure. We have been particularly impressed with the satisfactory way these latter individuals hold up under thyroidectomy once cardiac reserve has been restored.

Our experience with syphilitic heart disease has been in no way unusual. One feature, above all others, stands out here—the presence of anginal pains in luetic aortitis or aortic insufficiency is a very bad prognostic sign and usually means six months to a year of life at the most.

The neurogenic and psychogenic cardiac disturbances are undoubtedly a much greater part of our cardiac load than they would be in everyday practice. Neurocirculatory asthenia is the most common condition found—anxiety cardiac neurosis are fairly common, and neurogenic disturbance, as shown by paroxysmal tachycardia, AV block, et cetera, do occur occasionally. Furthermore, the problem of deciding which symptoms are due to the patient's organic lesion and which are psychogenic in origin can at times be very troublesome.

A few words now about some unusual cases, and those of unusual interest. We have had one case of beriberi heart in a chronic alcoholic who was admitted with edema, ascites, pulmonary rales, cardiac enlargement, anemia, and dyspnea—all of which failed to respond to digitalis and diuretics, but responded promptly to vitamin B in large doses —the tip-off being the EKG showing extremely low voltage of all the complexes, the anemia, and the history.

We have had one case of tuberculous pericarditis with some involvement of the myocardium and practically none of the lungs in a man in his late forties, admitted because of fever which ran up to 103° and 104° throughout his hospital stay, the patient manifesting, in addition, a leukocytosis, anemia, and cachexia, and being suspected at first of having a subacute bacterial endocarditis, but his blood culture proved to be negative. This patient later developed pericardial tamponade, was tapped, and

straw-colored fluid obtained which was inoculated into a guinea pig and reported (unfortunately postmortem) as positive for tuberculosis. Subsequently, the patient developed signs of cardiac enlargement, myocardial involvement, and died in failure—postmortem showing tuberculosis of the pericardium with myocardial degeneration but no actual involvement of the myocardium by the tuberculous process itself.

There have been four cases of congenital heart disease observed here in the past four years. The first of these was a simple case of right-sided aortic arch in a middle-aged male who had absolutely no symptoms referable to the CR system, but who was erroneously diagnosed as aortic aneurysm on several different occasions until the true state of affairs was realized. The second case was one of coarctation of the aorta with severe hypertension in the upper extremities, almost absent femoral pulsations, and, on x-ray, scalloping of the lower rib borders, prominence of the pulmonary conus, and an almost absent aortic shadow. The third case was one of congenital dilation of the pulmonary artery with, as far as could be established, no associated anomalies—as shown by a loud systolic murmur throughout the precordium, loudest in the third, left interspace, with prominence of the pulmonary conus on x-ray and markedly vigorous pulsation of the hila on fluoroscopy. The final case was one of patent ductus arteriosus in a man who had gone through fifteen years of military service with no ill effects and in whom the significant findings were a loud machinery-like systolic murmur occupying all of systole, loudest over the pulmonic area, and accompanied by a systolic thrill, a questionable pulmonic diastolic murmur, and marked prominence of the pulmonary conus on x-ray.

We have been impressed by two cases of spontaneous pneumothorax following pulmonary infarction, and softening with resultant rupture of the infarct—both of these being cases of rheumatic heart disease with auricular fibrillation; also by three cases of Malta fever acompanied by a mitral systolic murmur, anemia and fever so that subacute bacterial endocarditis was at first considered —the diagnosis being established from the history and the positive agglutination tests after first being suspected because of the rarity of auricular fibrillation in subacute bacterial endocarditis. We have seen one case of dissecting aneurysm of the aorta with rupture into the left pleural space and the retroperitoneal tissues, with death from hemorrhage but with pulsation good in both femorals so that this case was at first mistaken for a coronary occlusion and proved only by autopsy.

In short, we have seen practically every type of heart disease possible. The moral seems to be that in a veterans hospital, as elsewhere, the unexpected is everyday commonplace in medicine.

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# ALLERGIC MANIFESTATIONS

MAURICE S. FOX, M.D.

VINCENNES

During twelve years of clinical practice I was often amazed at the frequency with which patients mentioned the word "allergic." This was most outstanding in the group of patients who were being interviewed for the first time, and who had been under many forms of treatment and with different types of diagnosis. I think our so-called "big clinics" were as much at fault as were our general practioners. It seems that each time a new physician was consulted it was the patients' idea that perhaps he was allergic to something, and that that would be the solution to his problem. I think that a condition which has been recurrent at frequent intervals over a long period of time, although not disabling, is one which is of primary importance to the patient, and often assumes the proportion of immensity which equals the ordeal of a major operation. I think the two extremes of opinion might be cited as follows: the mother who feels she is allergic to her husband because she has had seven children, and the doctor who treats and diagnoses the inhalant allergenic patient as having spring, summer, fall, or winter flu, as the season indicates.

In the practice of allergy we find that most of the patients who consult us have a long and elaborate history of examinations and types of treatment which have been of no avail. This does not include the seasonal vasomotor rhinitis patient who has usually been overtreated with stock extracts for pollen therapy, or who has a concurrent inhalant or food sensitivity which is not being corrected. This latter class of patients soon fall into the class of "gripers" and "complainers" who know from their own experience that nothing will do them any good. They spread their "gospel" among their brethren, and the allergist must spend hours every week in his office explaining the why and wherefore of Mrs. Jones' failure to receive relief from some injections given her for hayfever. Again and again the importance of concurrent inhalant or food allergies must be explained.

Many of our patients first confront us with the question, "Why is there so much allergy now, or is this a new disease which has suddenly cast itself upon mankind?" I think the logical answer to such a question is the statement that the "allergic syndrome" of itching, sneezing, and limitation to certain portions of the day, is being more and more

recognized by the physician. The hereditary tendency to develop an area of shock tissue, by routine propagation of the human race, tends to increase the incidence of our allergies. It is hard to explain to the grandmother of a five-year-old hayfever patient that her eczema of forty years' standing may be the background of the child's seasonal vasomotor rhinitis. Then it is marvelous how she will remember that her son or daughter, the child's parent, had a "skin disease" until it was two years of age, and then suddenly got well. The importance of family history as regards so-called "chronic conditions" is of extreme importance, not forgetting that such conditions as "bloating," "sick headaches," and "chronic bronchitis" must be considered as allergic manifestations in a large percentage of cases.

I think our simple laboratory procedures can guide us through the many pitfalls of false diagnosis in allergic conditions. The true case of seasonal pollen vasomotor rhinitis is never confused with a sinus condition, but the same clinical picture in the winter months is often treated as an infection, although pale edema, sneezing, and watery discharge are symptoms which cry out for a correct diagnosis. By the simple method of a nasal smear the difference between inhalant allergy and food allergy of infection may be clearly seen. The eosinophils, which in many instances are the only cell on the slide, indicate a true allergic condition. Often after a few days or a week the nasal picture changes, due to secondary invaders, and we begin to get many neutrophils due to secondary infection. The large percentage of our otolaryngologists are now carefully checking this factor.

In order to illustrate some of the foregoing facts, I would like to cite the following case histories in which a correction of their inhalant, contact, or food allergies corrected their long-standing problem. I do not wish to leave the impression that all long-standing problems are all on an allergic basis, but to stress the fact that such a basis should be considered in the differential diagnosis. These cases are illustrative of the various types encountered. These are selected as a non-occupational group, and ones in which there was no concurrent organic disease. All negative laboratory data is not included, only the pertinent facts regarding skin reactions.

*Case I:* Mr. R. G., aged fifty—Last December patient began having extreme nasal stuffiness, headache, and severe coughing spells, with asthma at night. This was treated as a "cold" for two months. On examination, nasal smear showed 3 plus eosinophils. Two years ago patient began raising chickens as a hobby. On survey he was found 4 plus to chicken feathers, 2 plus to our No. 2 pooled dust, and 4 plus to mattress linters. Desensitization and avoidance by covering mattress gave complete relief.

*Case II:* Mr. J. D., aged forty-two—For past five years patient had an oval lesion on dorsum of right forearm about 8 cm. long and 4 cm. wide. There was a concurrent irritation and itching of the scalp. This case had been treated as ringworm, eczema, and psoriasis at intervals. On survey this patient was found 3 plus to our No. 2 pooled dust, and 2 plus to mattress linters. Desensitization and avoidance by covering mattress caused the lesion to disappear in three weeks. This patient slept with his right arm under his pillow.

*Case III:* Miss A. L., aged forty-five—For past ten years patient has complained of a nasal drip and tendency to want to clear throat. Would awaken at night. Was told at one of our large clinics that this was a "nervous mannerism." Had been treated with all types of nose drops and local applications. On survey patient was found 2 plus to chicken feathers, 3 plus to turkey feathers, 2 plus to No. 2 pooled dust, and 2 plus to wool. She also gave a 3 plus to bakers' yeast. Patient was asked to cover her mattress and pillow, and desensitization was started with the inhalants. There was marked improvement in her case, even the day after her testing. Patient was also asked to avoid bakers' yeast.

*Case IV:* Miss J. W., aged five—Patient had a stuffiness in her nose for the past two winters, which was some better during the summer. These were always worse on Saturday and Sunday, and improved some by Monday. The little girl liked to help her mother clean house, which was always done on Friday afternoon. By Friday night her throat was sore, and she was coughing. Patient had been treated for sinus trouble, and twice for pneumonia, at which time there was possibly an asthmatic tendency. On survey, patient was 3 plus to goose feathers, 3 plus to No. 1 pooled dust, and 2 plus to June grass, timothy, and red sorrel. Covering the mattress and pillows and desensitization gave complete freedom.

*Case V:* Mrs. E. F., aged thirty-six—Patient entered nurses' training in the fall of 1926, and the following fall developed a dermatitis of both hands which lasted all during the cool weather. For the next four years this was treated with all types of ointments and roentgen therapy, under the direction of a competent dermatologist. There was a loss of two or three nails each winter. Following an allergic survey a marked reaction to oidiomycin (4 plus) was discovered, and desensitization was carried out with complete recovery.

*Case VI:* Miss M. A., aged twenty-five—For the past two years this patient has had attacks of severe rhinitis, headache, sore throat, and asthma-type attacks with a great deal of coughing. Had been frequently treated with sulfa drugs and sulfa drops for sinus infection. On survey patient was found very sensitive to chicken, duck, and goose feathers, No. 2 pooled dust, Staphylococcus aureus and Streptococcus non-hemolyticus. Desensitization resulted in relieving all symptoms except a periodic severe flare-up. Patient was asked to test her cologne by nasal test, and found two which readily produced symptoms. Avoidance of these kept her relatively free of discomfort. Avoidance

of these is difficult in theaters or public gatherings.

*Case VII:* Mrs. M. C., aged forty-five—For the past two winters patient had had a severe coryza and conjunctivitis which would occur suddenly, last for several hours, and then disappear. She had been treated with nasal packs and bacterial injections with no result. Patient stated she lived in a doctor's office in the winter time. In taking the history I became suspicious of a cosmetic and learned that at the time this started she had had prepared for her a special face powder. Taking a sample from her compact, the "powder puff" nasal test was applied, and this produced a typical attack with persistent violent sneezing for fifteen minutes. A consequent survey showed Staphylococcus aureus 3 plus, No. 1 dust 3 plus, and orris root 2 plus. Desensitization and using an "orris free" powder gave complete relief.

*Case VIII:* Mrs. H. A., aged sixty-eight—For the past year patient had had a severe cough, nasal drip, asthma-type seizures, and nasal block. She was pale, asthenic, and had been unable to rest at night because of the necessity of clearing mucus from her throat. She was referred by an otolaryngologist. On examination her nasal mucus showed 4 plus eosinophils, with pale congested mucous membrane and a copious amount of cloudy mucus on the posterior pharyngeal wall. Survey revealed chicken and goose feathers 2 plus, No. 1 dust 2 plus, orris root 2 plus, cottonseed 2 plus, and Staphylococcus albus 2 plus. Desensitization and avoidance gave complete relief. Patient gained weight, and now has a healthy, normal appearance.

*Case IX:* Mrs. D. K., aged twenty-nine—For several months this patient had a dermatitis involving arms, legs, and back. The itching was very intense and would keep the patient awake at night. As she stated, it was making a "nervous wreck" of her. On survey she was found to be 2 plus to No. 2 dust, 3 plus to mattress linters, and 1 plus to cottonseed. The latter was not considered important at the time. Desensitization gave no relief, and after four weeks patient was asked to use a shortening which did not contain cottonseed. In forty-eight hours her symptoms subsided, and in one week her skin had returned to normal.

*Case X:* Mrs. M. D., aged fifty-eight—For eight years this patient had had a nasal block which prevented breathing through her nose except for short periods. She had had five operations for removal of nasal polypi. The last one was four months prior to her visit to my office. On examination the nasal smear showed 4 plus eosinophils, and the mucous membrane was pale and conjested to a point where I was unable to see the middle or superior turbinate. On survey she was found to be 2 plus to chicken, duck, and goose feathers, 3 plus to No. 1, 2, and 3 dust, 3 plus to mill-dust extract, 2 plus to orris root, and 2 plus to old kapok. Covering pillows and mattress and desensitization to inhalants has relieved this patient completely.

Conclusion:

1. Many chronic, nasal and bronchial conditions are of an allergic basis.
2. Inhalation factors are of prime importance in this class of patients.
3. A careful history will usually allow the practitioner to determine whether or not a clinical problem is of an allergic basis.
4. Long-standing problems which are not debilitating should first have allergy ruled out.

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## ABSTRACT: PENICILLIN CAN BE ADMINISTERED BY MOUTH

Until only a short time ago, general use of penicillin by the medical profession had been limited to those products which could be injected into a vein or muscle. In the August 18 issue of "The Journal of the American Medical Association," the United States Food and Drug Administration tells how penicillin can be administered by mouth in the form of capsules and lozenges, how it can be applied as an ointment, and, also, how it can be used in dental cones.

"The Journal's" article was prepared by Chester S. Keefer, M.D., of Boston, chairman of the Committee on Chemotherapeutics and Other Agents of the National Research Council, and Medical Administrative Officer to the Committee on Medical Research of the Office of Scientific Research and Development, in cooperation with three physicians of the United States Food and Drug Administration in Washington—Robert P. Herwick, Walton Van Winkle, Jr., and Lawrence E. Putnam.

In reviewing the fields in which the various penicillin products can be used, the article said that all the information was "based on a review of the available scientific evidence and on information developed in consultations with experts in the field of chemotherapy and the medical and scientific staffs of interested manufacturers. The suggestions regarding indications, dosages and precautions reflect as closely as possible the experience of experts in penicillin therapy."

They say that the dosage of penicillin will vary from one patient to another, depending on the type and severity of infection. The objective in every case is to bring the infection under control as quickly as possible.

When penicillin capsules or lozenges are taken by mouth, the potency of each capsule or tablet is not less than 20,000 units, and the "number of tablets or capsules in each single package is such that the total number of units therein is not less than 300,000."

Penicillin tablets have been found beneficial in the treatment of "trench mouth." Tablets can be dissolved in the mouth two or three times a day between meals.

Penicillin by mouth should be administered on a fasting stomach, not less than thirty minutes before or not less than one and one-half to two hours after eating.

Penicillin ointment is packaged in collapsible tubes. For superficial infections of the eye, penicillin ointment may be applied one or more times a day as the condition indicates. It may also be used for superficial infections of the skin caused by organisms susceptible to penicillin.

Penicillin dental cones have a potency of not less than 500 units. A cone can be inserted after tooth extraction or as treatment for dry socket.

Conditions in which penicillin has been found effective include:

Soft tissue abscesses, meningitis, pneumonia, wound infections, burns, inflammation of the lining of the heart, gas gangrene, ear infections, peritonitis, all streptococcic, pneumococcic, and the gonococcic infections, and "trench mouth."

Conditions in which penicillin is ineffective include:

Typhoid, dysentery, tuberculosis, acute rheumatic fever, Hodgkin's disease, acute and chronic leukemia, ulcerative colitis, malaria, poliomyelitis and other virus infections and cancer.

# PENICILLIN BY MOUTH IN COMBINATION WITH ALUMINUM DIHYDROXYAMINOACETATE*

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In a former article it was shown that penicillin by mouth could be effective when administered in combination with a suitable antacid.[1] Sixteen patients with gonorrhea and one with otitis media complicating scarlet fever were successfully treated in this manner. Penicillin powder was dissolved in 100 cc. of water, and one gram of the antacid was added to the solution. This mixture had to be freshly prepared each time a dose of the drug was prescribed. The antacid used to buffer the acidity of the stomach was aluminum dihydroxyaminoacetate. This combination of aluminum and glycine was chosen because it buffers the gastric juice faster than aluminum hydroxide, has a prolonged effect, and keeps the gastric contents within the pH range which will prevent inactivation of penicillin.[2, 3] Since our previous article we have been using tablets containing 0.5 gram of aluminum dihydroxyaminoacetate and either 10,000 or 20,000 units of dry sodium penicillin. The tablets were stable over a period of months if kept in a refrigerator.

Rammelkamp and Keefer[4] showed that when penicillin was injected intravenously the concentration in the blood reached its peak immediately, and thereafter fell at a rather rapid rate. A dose of 40,000 units produced a maximum level of 2.5 Oxford units per cubic centimeter of serum which took one hundred eighty-five minutes to fall to subinhibitory level. Following intramuscular injection, maximum blood concentrations were achieved more slowly and were somewhat more sustained. With subcutaneous injection, both absorption and elimination were even more delayed.

Burke, Ross, and Strauss[5] showed that adequate pencillin blood levels were obtained by oral administration when the drug was protected from the inactivating action of hydrochloric acid in the stomach. Krantz, et al.,[6] gave twelve medical students 100,000 units of penicillin dissolved in water and mixed with three grams of aluminum dihydroxyaminoacetate. They found 68 Oxford units per 100 cc. of serum three hours after the drug was given, and 17 Oxford units as long as seven hours after the ingestion of penicillin. We have been able to confirm this observation with tablets of penicillin and aluminum dihydroxyaminoacetate instead of the drug in solution. To ascertain the blood level when the drug was given in divided doses we gave a patient five tablets (50,000 units) every hour for six hours, making a total of 300,000 units of penicillin. Blood was drawn one-half hour, one hour, one and one-half hours, and two hours after the last dose was taken. All specimens contained 50 Oxford units per 100 cc. of blood serum, showing that a constant level is maintained for several hours after ingestion of the drug. Another patient who was given 20,000 units per hour (2 tablets per dose) excreted one Oxford unit per cc. of urine shortly after the second dose, or 40,000 units of the drug.

This combination of penicillin and aluminum dihydroxyaminoacetate was used in the treatment of several types of infection. The first group of patients were those with gonorrhea. These patients responded readily to this medication and mode of administration. Two tablets (20,000 units) were given every hour for five hours. This was repeated on the second, and in an occasional case on the third day, making a total of 200,000 to 300,000 units. It was felt that it was better to give a larger dose than would ordinarily be considered necessary, rather than take a chance on inadequately treating the infection. The disappearance of gonococci was checked both by smear and culture. The following is a typical example of such cases:

### CASE I

D. A., a female, aged seven, was admitted to the University Hospitals because of abdominal pain. Between the age of one and six she had scarlet

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[1] Paul, W. D; Rhomberg, C.; McKee, A. P., and Pichette, J. W.: Administration of Penicillin by Mouth in Combination with Aluminum Dihydroxyaminoacetate. *J. Iowa M. Soc.*, **xxxv**:219-221, (June) 1945.

[2] Paul, W. D., and Rhomberg, C.: Medical Management of Uncomplicated Peptic Ulcer. *J. Iowa M. Soc.*, **xxxv**:167-185, (May) 1945.

[3] Krantz, J. C.; Kibler, D. V., and Bell, F. R.: Neutralization of Gastric Acidity with Basic Aluminum Aminoacetate, *J. Pharmacol. and Exper. Therap.*, **lxxxii**:247-253 (Nov.) 1944.

[4] Rammelkamp, C. H., and Keefer, C. S.: The Absorption, Excretion, and Distribution of Penicillin, *J. Clin. Invest.* **xx**:425-437, (May) 1943.

[5] Burke, F. G.; Ross, S., and Strauss, C.: Oral Administration of Penicillin, A Preliminary Report, *J. Amer. Med. Assoc.* **cxxviii**:83-87, (May 2) 1945.

[6] Krantz, J. C.; Evans, W. E., and McAlpine, J. G.: Oral Penicillin with Basic Aluminum Aminoacetate, *Science*, **ci**:618-619, (June 15) 1945.

fever, chicken pox, measles, and whooping cough. She had been constipated most of her life, with a bowel movement sometimes daily but usually every other day. The stools, as a rule, were hard and chunky, and on occasion she passed one to two pounds of feces. During the preceding year the constipation became more marked and she noticed pain over the left side of the abdomen. The distress at first was intermittent, but during the week before admission it became constant. At no time did she have fever, chills, nausea, or vomiting. Her mother was not aware that the child had a vaginal discharge. No history of infection in the family was available.

The physical examination was essentially negative, except for the pelvic examination. The labia majora were red and irritated by dried exudate. There was considerable dried and fresh yellowish-white, thick, purulent vaginal discharge. The labia minora were only slightly inflamed.

The urine was essentially normal. The hemoglobin content was 13.0 gms. (Haden-Hauser), the erythrocyte count 4.7 million per cc., the leukocyte count 9.6 thousand per cc., and the differential count normal. Roentgenologic examination of the colon after a barium enema was negative. Smears from the vagina showed many gram-negative diplococci, both intra- and extra-cellular. Cultures of the vaginal exudate grew out many colonies of Neisseria gonorrhoeae.

One gram of sulfathiazole and two grams of sodium bicarbonate were given every six hours. This medication was continued for a ten-day period. Four days after sulfathiazole was started Neisseria gonorrhoeae could still be cultured for the vagina. Ten days after the start of medication the discharge was still present and gram-negative diplococci were present in the smears, but the cultures showed no gonococci. The sulfathiazole was discontinued, and after this the organism again grew in culture. Two tablets of penicillin were given every hour for five hours, making a total of 100,000 units. This dose was repeated the second and third day. Repeated cultures were taken every day for five days after penicillin was started, and remained sterile. Smears no longer revealed any gram-negative diplococci. The discharge and signs of irritation disappeared within forty-eight hours. She was re-examined three weeks later, and no evidence of vaginitis was found.

Another group of patients who responded to penicillin by mouth had prostatitis. The causative agents in the cases in which the treatment was successful were Alpha hemolytic streptococcus, Staphylococcus albus, and in one case a pneumococcus. This later organism was recovered from both the urine and urethral smear. It was isolated in pure culture and found to be penicillin-sensitive. The type was not ascertained because it was beyond type 33. All the patients in this group were given 100,000 units a day for five days (total of 500,000 units) even though the organism could not be cultured after the first twenty-four hours. Penicillin by mouth had no effect on prostatitis caused by the paracolon bacillus.

Penicillin was administered by mouth by the otolaryngologist to a number of selected patients with infections of the upper air passages or auditory apparatus. Evaluation of the results was based on subjective relief, clinical observation, and laboratory tests. At first the results were equivocal, probably because of inadequate dosage. When the amount of penicillin was increased to 300,000 units per day, and repeated for one or more days, the improvement was more striking. Complete data on these subjects will be reported later.

When early syphilis was first treated with penicillin it was noted that the patients developed general malaise, mild pyrexia, and enlargement of the inguinal nodes. Ross and his co-workers[7] have shown that these effects might be attributed, at least in part, to a mild Herxheimer reaction. Mahoney, et al.,[8 9] reported that during the first eight hours of treatment of early syphilis the patients complained of general malaise and headache. There were elevations of temperature, not in excess of 2° F. The penile lesion became painful and the regional lymph nodes became enlarged and tender. One patient displayed a maculopapular rash resembling that of secondary syphilis over the trunk and thighs. The eruption was of short duration. There were no symptoms which could be attributed to a toxic response to the drug. If the Herxheimer reaction is provoked by giving penicillin intramuscularly, this phenomenon might be used to indicate whether or not the drug is effective when given orally. We do not recommend the use of penicillin by mouth for the treatment of syphilis, but report the following cases to show that the drug is absorbed from the gastrointestinal tract when the gastric juice is adequately buffered.

### CASE II

*History*—J. H., aged eighteen, was referred to the University Hospitals by the local authorities for the treatment of syphilis. He first noticed a urethral discharge and a penile lesion nine days after sexual contact. Four days after the appearance of the chancre he was given eight "sulfa" tablets, and this was repeated the following day. This medication had no effect on the penile lesion, but he thought that the discharge was less profuse.

Physical examination on admission was entirely negative except for the genitalia. There was a thick, yellowish discharge. The glans penis was red and edematous. On the posterior surface of the glans, at the corona, there was an indolent, in-

[7] Ross, A. O. F.; Nelson, R. B.; Lourie, E. M., and Collier, H. O. J.: Treatment of Early Syphilis with Penicillin, *Lancet* **ii**:845-848, (Dec. 30) 1944.

[8] Mahoney, J. F.; Arnold, K. C., and Harris, A.: Penicilin Treatment of Early Syphilis: A Preliminary Report, *Am. J. Pub. Health* **xxxiii**:33:1387, (Dec.) 1943.

[9] Mahoney, J. F.; Arnold, K. C., and Harris, A.: Penicillin Treatment of Early Syphilis: A Preliminary Report, *Ven. Dis. Inform.* **xxiv**:24:355, (Dec.) 1943.

**TABLE I**

**RESULTS OF PENICILLIN THERAPY**

| Time | Dosage in Units | Urethral Smear | Urethral Culture | Darkfield | Temperature | Skin Lesions |
|---|---|---|---|---|---|---|
| 4/1/45 | | | | | | |
| 9:30 A.M. | 20,000 | + | + | + | 98.8°F | O |
| 10:30 A.M. | 20,000 | + | + | + | | O |
| 11:30 A.M. | 20,000 | + | + | + | 98.6°F | O |
| 12:30 P.M. | 20,000 | + | + | + | | O |
| 1:30 P.M. | 20,000 | + | O | + | | O |
| 2:30 P.M. | 20,000 | + | O | + | | O |
| 3:30 P.M. | 60,000 | + | O | + | | O |
| 4:00 P.M. | 60,000 | O | O | | | O |
| 5:30 P.M. | | O | | | | O |
| 6:30 P.M. | | O | | O | 101 ° F | ++++ |
| 7:00 P.M. | 60,000 | O | | | 101 ° F | ++++ |
| 7:30 P.M. | 30,000 | O | O | | 101.6°F | ++++ |
| 9:30 P.M. | 30,000 | O | O | O | | ++++ |
| 4/2/45 | | | | | | |
| 9:00 A.M. | | O | O | O | 97.4°F | O |
| 3:00 P.M. | | O | | | 98.0°F | O |

durated, slightly tender ulcer measuring 5 x 3 mm. in diameter.

The urine contained many pus cells, but was otherwise normal. The hemoglobin was 14.5 gm. (Haden-Hauser), the erythrocyte count 4.73 million per cc., and the leukocyte count 4,750 per cc.; the differential count was normal. Serologic examination of the blood on admission showed a positive Kolmer, positive Kahn, and positive Kline, with 80 Kahn units. Darkfield examination of material from the penile lesion revealed Treponema pallidum in great numbers. Smears from the urethra showed numerous gram-negative diplococci, both intra- and extra-cellular. Cultures grew out many colonies of Neisseria gonorrhoeae.

He was given two tablets of penicillin (20,000 units) every hour for six hours. After the fourth hour he still had a discharge which contained gonococci, and treponemata were still present and motile. After the sixth dose, making a total of 120,000 units, the smear still showed gram-negative diplococci, and the spirochetes could still be demonstrated on darkfield examination, but cultures of the urethral discharge were negative. At this time the patient complained of fatigue, generalized aches, pains, and headache. He was then given six tablets (60,000 units) of penicillin orally at one time, and an hour later another six tablets (60,000 units). About the seventh hour after treatment was begun the discharge practically stopped, and no gonococci could be found in the smear or culture. Darkfield examination revealed only an occasional spirochete, and these moved very sluggishly. The darkfield examination for Treponema pallidum became completely negative between the sixth and ninth hours of treatment, and was negative on subsequent examinations. The patient's temperature rose to 101.6° F., he had marked malaise, some joint pain, tender, slightly enlarged inguinal nodes, and a typical maculopapular eruption of secondary syphilis over the body. That evening he was given another six tablets (60,000 units) of penicillin. The next day the temperature was normal, the skin rash had faded, and he felt very well. (See Table I). In the Department of Dermatology and Syphilology his treatment was then continued by the standard methods. Table I outlines the results obtained in this study. Another patient with typical lesions of secondary syphilis on the palms and soles, and eroded papules on the vulva, was given 20,000 units of penicillin by mouth every hour, with approximately the same results. The darkfield examination of material from the vulvar lesions was positive for Treponema pallidum before treatment was begun. At the end of the eighth hour, after she had taken a total of 180,000 units of penicillin, she developed a generalized maculopapular rash, a few tender inguinal nodes, malaise, and slight injection of the sclerae, but no rise in temperature. The darkfield examination at this time was still positive for Treponema pallidum. Sixteen hours after penicillin was started the treponemata were no longer found on darkfield examination.

The above cases clearly show that penicillin is effective when given orally. It can be used by mouth in the treatment of those infections which result from penicillin-sensitive organisms. The oral dose may be no greater than the amount given intramuscularly, at least in some infections such as gonorrhea, and may or may not be larger in other types, such as acute purulent sinusitis. Further clinical experience is needed to ascertain the effective dosage. It must be remembered that this drug, regardless of the route whereby it is administered, is no panacea for all infections. One patient who developed pyelitis was given penicillin by mouth before the bacteriological studies were completed. She received no benefit from the medication. A paracolon bacillus was isolated from her urine, and this organism was proved to be resistant to penicillin.

In conjunction with the Department of Ophthalmology a number of cases of ocular inflammations have been treated with oral penicillin. These cases which include acute conjunctivitis, chronic blepharoconjunctivitis and corneal ulcers responded favora-

bly in from twenty-four to forty-eight hours. A detailed report will be made later.

### CONCLUSIONS

Penicillin can be absorbed from the gastrointestinal tract when buffered with an effective antacid, such as aluminum dihydroxyaminoacetate.

Tablets of the above mixture have been used effectively in many types of infection caused by penicillin-sensitive organisms.

Penicillin by mouth can provoke a Herxheimer reaction in early syphilis.

Penicillin by mouth can cause the lesions of early syphilis to become darkfield negative for Treponema pallidum within approximately the same number of hours as penicillin given by intramuscular injection for the same type of lesions.

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# TRANSVERSE INCISION IN PELVIC OPERATIONS*

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VINCENNES

In choosing an incision for a pelvic operation the operator should use an incision that affords him ample room for work and easy access to the pelvis, and should take into consideration the after-effects to the patient from the operation. In lax abdominal walls, especially in women who have borne a number of children, the operator always has in mind the possibility of a postoperative hernia.

In 1896, Kustner and Rapin, at the Second International Congress for Gynecology and Obstetrics, presented a method then new to the profession, of opening the abdomen with a transverse incision in the place of the median line incision. This incision was made in the region of the superpubic hair, in a transverse direction through the skin and subcuticular tissue, but the fascia as well as the peritoneum was divided vertically in the median line. Pfannenstiel, in 1900, modified this incision by incising the fascia also in a transverse direction, separating it both above and below from the underlying muscles by a blunt dissection and entering the abdomen through the linea alba and the peritoneum. This modification was devised to abolish postoperative hernia. By this transverse method of dividing the fascia Pfannenstiel perfected one of the principal advantages to be derived from the procedure, because the fascia is now left completely intact over the vertical incision in the linea alba, thereby eliminating the unfavorable tension exerted by the transverse and oblique muscles of the abdomen on the fascial scar. Hartman, of Paris, and Stimson, of New York, had independently practiced the transverse fascial incision, but Pfannenstiel enjoyed the honor of being the first to plan, execute, and publish the incision which bears his name.

The technique is as follows: the patient is placed level on the table (I never use Trendelenburg position any more as I do not find that it is necessary) and a transverse incision is made either in the transverse skin fold, or at the edge of the superpubic hair just below it. The length of the incision varies from three to six inches. The wound is then stretched with the fingers for enlargement, better exposure of the fascia, and the hemostatic effect it produces. Few vessels are divided, giving rise to a minimum amount of hemorrhage and causing little interference with the subsequent nutrition of the flaps. It is seldom necessary to ligate more than two or three vessels in the wound, and often no ligation is needed, thereby reducing the amount of foreign material introduced which, of course, has an important bearing on wound union. We should be sure that there is no hemorrhage or oozing under the flap, for if there is it will come out through the incision, usually at the mid-line, some ten days after the operation. The fascia is next divided in a transverse direction as far, if necessary, as the outer border of the recti muscles, and often one or two inches nearer the pubes, because we all know that in pelvic surgery an inch below is worth two above. If it is necessary to extend the fascial incision, it should curve up to avoid injury to the external rings. This is the most important part of the incision, for an injury to the external rings will sometimes result in hernia. The length of the fascial opening depends on the size of the vertical incision in the peritoneum. We now have the fibers of the skin, nerves, and fascia divided in a vertical direction. It is seldom necessary to use retractors as the uterus can be brought out of the abdomen; the upper flap covers the intestines, and few, if any, laparotomy pads are necessary, thus preventing one great cause of postoperative adhesions.

The advantages to the patient are of extreme importance. A perfect exposure and an easy access to the pelvic organs thus afforded lessens greatly the amount of intra-abdominal manipulations, and as a result a comparative freedom from shock and postoperative complications.

Advantages to the operator: The incision thus made is in close proximity to the pelvic organs, allowing the operator to work to the greatest ad-

* Presented before the Knox County Medical Society at Vincennes, on February 13, 1945.

vantage since the opening centers the field of operation, giving him free access in every direction and not compelling him, as one well known operator has said, to work in the lower end of a rigid "V."

The muscles being free from their overlying fascia are easily drawn aside, and can be kept out of the way with a minimum amount of force. Since the long axis of the incision runs from the adnexa of one side across the fundus, and to the adnexa of the other, a maximum exposure is offered with a minimum incision.

To secure the strongest wound after operation, the incision must be made in the strongest part of the abdominal wall by a method that will interfere as little as possible with the integrity of the fascia and muscles. We find that spontaneous hernia is seldom, if ever, found in the lower half of the distance from the umbilicus to the symphysis pubis, since it is a region abundantly supplied with strong muscular tissue lying in close proximity and strengthened by the overlapping pyramidalis. The upper half of the distance is the weakest part of the abdominal wall, excepting the abdominal rings, because here the recti broaden, thin out, and separate to pass the umbilicus. Due to the simple separation of the recti and thinning of the fascia caused by pregnancy or large abdominal tumors, hernias are often seen here. It would seem that this is one region to stay away from, so as not to further weaken it. The bladder lies close to the peritoneal scar, and as it fills it pushes the intestines away, thereby preventing their adhesion to the wound.

In more than one thousand operations in which I have used this incision I have not had one case of acute dilatation of the stomach, nor one of postoperative ileus; in fact, the abdominal distention was conspicuous by its absence. In this series of cases a large per cent of them were infected cases, and drainage was necessary. These infected cases cleared up and healed as rapidly as those in which we used a longitudinal incision, with no postoperative hernia, as I have had in some of my longitudinal incisions.

Childs, Tovey, and Wells, of the New York Polyclinic, gave reports on this incision some thirty years ago, in which they had their patients out of bed on the second and third day after the operation, and sent them home on the seventh or eighth day following the operation. It is my experience that sitting these patients up on their second and third day is an advantage, and that many are able to be sent home by the seventh or eighth day following operation.

Permit me to quote from the report of M.le Doctor Rouffart, of Brussels, Belgium, at the first meeting of the Association des Gynecologues et Obstetriciens de langue francaise: "The superiority of the transverse incision over the longitudinal incision from the anatomical and clinical standpoint will cause it to be chosen in the majority of gynecologic and obstetric laparotomies."

## DISCUSSION

Paul B. Arbogast, M.D., Vincennes: In discussing this subject of transverse incisions, I wish to say at the outset that Doctor Curtner has admirably described the technique as well as the advantages of this type of incision, some of which will bear repeating.

Its chief advantage, other than its relative freedom from postoperative herniation, is the wide exposure it affords the surgeon. When properly made, the widest extent of exposure is from one adnexa to the other, directly over the vesicouterine foid. This exposure is sufficient to perform the average hysterectomy without any retractor other than one to cover the bladder, which should be empty; and if necessary, it should be kept so by an indwelling catheter for prolonged procedures. Now a word of caution: it is well to open the peritoneum high in the exposed area to preclude the possibility of injury to the bladder; extend the incision downward toward the bladder as far as is needed.

When this incision is used in connection with spinal anesthesia the exposure afforded in combination with the intestinal relaxation obtained with the spinal anesthetic is sufficient to perform most any pelvic procedure without any retractor or lap sponges, the uterus being lifted up and retained in the lower angle of the wound by a Simpson uterine-elevating forceps.

Doctor Curtner did not discuss the closure. It should be done in a definitely meticulous manner. After peritoneal closure, including the posterior rectus sheath, has been completed, the muscles must be approximated. One mattress suture placed through the pyramidalis muscle, one high under the flap, and one midway between are usually sufficient. Before closing the fascia be certain that hemostasis under the fascial flap is complete, otherwise drainage may occur postoperatively. The fascia is closed by a continuous lock-stitch suture, care being taken to include the fascial layers of both the internal and external oblique.

It has been our practice to use clips for skin closure as we feel that it produces a neater scar. The skin scar does not spread as there is no tension, and in a few months' time it is practically inconspicuous. This cosmetic effect is especially valuable in younger women with the present-day vogue for two-piece swimming suits, sun suits, et cetera, as the regrowth of pubic hair conceals the faint scar that persists.

In closing, let me state that in my opinion the advantages afforded by this type of incision greatly outweigh its only drawback, that is, the length of time needed for the exacting closure which is somewhat greater than that required for the conventional mid-line incision.

# THE ANTISEPTIC PROPERTIES OF ISOPROPYL ALCOHOL IN RELATION TO COLD STERILIZATION

H. M. POWELL, Sc.D.*

INDIANAPOLIS

## INTRODUCTION

Some twenty years ago Grant[1] reviewed the action of isopropyl alcohol as an antiseptic on the basis of information which had appeared at that time in nine publications. It was concluded that isopropyl alcohol was somewhat stronger in antiseptic action than ethyl alcohol, and at the same time was about twice as toxic. Since isopropyl alcohol equalled or even surpassed ethyl alcohol in antiseptic strength, and is non-potable and not subject to restrictions and taxes, considerable practical use was foreseen in the field of antisepsis, particularly in the preservation of museum specimens and in what is commonly regarded as "cold sterilization." Possibly it might supplant ethyl alcohol in these fields where the latter, while effective in a practical way, might be used only at high cost and under restrictions.

About ten years ago we tested isopropyl alcohol for antiseptic action against various bacteria in controlled tests. The bacteria used included Staphylococcus aureus, hemolytic streptococcus, Bacillus coli, and Bacillus typhosus. In tests conducted at room temperature, thirty (and over, but not ten and twenty) per cent isopropyl alcohol was uniformly germicidal for all four of these organisms of determined phenol resistance in thirty-minute exposure. In tests conducted at 20° C., 50 per cent (and stronger) solutions of isopropyl alcohol were germicidal for Staphylococcus aureus #209 in five-minute exposure. Weaker solutions were not included in these particular tests.

At this time the stocks of isopropyl alcohol were found to be contaminated with a saprophytic spore bearer, presumably introduced sometime during manufacture or handling. This organism caused no difficulty in the practical use of isopropyl alcohol as a "sterilizing agent"[2] for syringes, needles, et cetera, but obviously was confusing in germicidal assays. At this point all the stock isopropyl alcohol was Berkefeld filtered (the material passing through filters very rapidly), and no further interference appeared in connection with bacteriological testing.

## EXPERIMENTAL

*Tests against non-spore bearers:* The present experiments were conducted with stock isopropyl alcohol 91 per cent received from a carbide and carbon chemicals corporation. Standard controlled germicidal tests were first conducted against Staphylococcus aureus #209 and Bacillus coli. Five cc. amounts of different percentage strengths of isopropyl alcohol from 10 per cent to 91 per cent (by increments of 10 per cent) were planted with 0.5 cc. doses of twenty-four-hour broth cultures of the respective organisms. Exposure was at 20° C., and subcultures were prepared, incubated, and read in the usual way.

Under these conditions, 40 per cent isopropyl alcohol (and stronger but not weaker dilutions) killed Staphylococcus aureus in five minutes. The same culture in the same test was killed by control phenol 1:60 but not 1:70. Also 30 per cent isopropyl alcohol (and stronger but not weaker dilutions) killed Bacillus coli. This same test culture was killed by control phenol 1:70 but not 1:80. All of these tests included five-minute exposure of bacteria to drug.

The above preliminary results verify our own former results, and nearly all previously-published results, and indicate that isopropyl alcohol is an effective antiseptic even when diluted to less than half strength.

*Rapid tests:* In view of the fact that both the former thirty-minute and five-minute exposure tests referred to in the introduction, and the five-minute exposure tests just described in connection with Staphylococcus aureus and Bacillus coli are of longer duration than would usually be consumed in "sterilizing" syringes, needles, et cetera, we conducted the following rapid test: five cc. amounts of eight isopropyl alcohol dilutions of 20 per cent to 91 per cent inclusive (with increments of 10 per cent) were planted with 0.5 cc. doses of twenty-four-hour culture of Staphylococcus aureus #209. Subcultures were made after one-minute exposure at 20° C., and incubated and read in the usual way. This test showed that 20, 30, and 40 per cent isopropyl alcohol did not kill the test staphylococcus culture in one minute, but 50, 60, 70, 80, and 91 per cent dilutions did kill under these conditions. This action appears sufficiently rapid to be of practical importance in "cold sterilization" of syringes, instruments, et cetera.

*Tests against spore bearers:* Bacterial spores are particularly resistant to antiseptic agents of all kinds, and the alcohols are no exception. Nevertheless, we conducted tests with eight dilutions of isopropyl alcohol (20 per cent to 91 per cent inclusive, as before) and a well-spored culture of Bacillus subtilis. Exposure was at 20° C., and sub-

* From the Lilly Research Laboratories, Indianapolis, Indiana.

[1] Grant, D. H.: The Antiseptic and Bactericidal Properties of Isopropyl Alcohol, *Amer. Jour. Med. Sci.*, **166**:261-265, 1923.

[2] Fantus, B.: Clinical Asepsis Instead of Bacteriological Sterility, *Jour. Amer. Med. Assn.*, **103**:108-109, 1934.

cultures were made after 5, 30, and 60 minutes. All these subcultures grew when incubated in the regular way, indicating isopropyl alcohol in the strengths used did not kill this spore bearer in exposures up to one hour. Similar tests were conducted with a well-spored culture of Clostridium novyi. The same dilutions of isopropyl alcohol were used, exposure was at 20° C., and all subcultures made after intervals of 5, 30, and 60 minutes grew out when incubated overnight, thus indicating lack of effectiveness against this spore bearer. From these negative results in long exposures it is doubly obvious that no spore killing could be expected in the brief exposures connected with cold sterilization of syringes, needles, et cetera. These results agree with the general results reported by Tanner and Wilson.[3]

## DISCUSSION

It appears without doubt that isopropyl alcohol is fully equal or even somewhat superior to ethyl alcohol in antiseptic action. The extent of antiseptic action of both these alcohols comprises rather rapid killing of non-spore-bearing bacteria. Gram positive bacteria (staphylococci) are readily killed, and so are gram-negative bacteria (colon bacilli). This action is apparent at ordinary room temperature, and also at 20° C. The test cultures killed by isopropyl alcohol under these conditions are of the usual standard resistance to phenol.

Isopropyl alcohol has been found to be effectively germicidal in one minute at 20° C. against Staphylococcus aureus #209. The concentration necessary for this is 50 per cent, as compared to a 40 per cent concentration of isopropyl alcohol which is effective in five minutes.

[3] Tanner, F. W., and Wilson, F. L.: Germicidal Action of Aliphatic Alcohols, *Proc. Soc. Exp. Biol. and Med.*, **52**:138-140, 1943.

As contrasted to a rather rapid and pronounced antiseptic activity against non-spore-bearing bacteria, we have found isopropyl alcohol, like all other usable preparations of this class, without germicidal action on spore bearers. As judged from such negative action of nearly all the known drugs of this class, it is apparent that originally the difficulty of obtaining germicidal action against spores was underestimated, and many early positive reports were erroneous.

It appears that the antibacterial potency of isopropyl alcohol is adequate for aseptic preparation of syringes, needles, et cetera, (instruments not harmed by alcohol) for safe human use. Absolute bacteriological sterility cannot be guaranteed with any procedure short of autoclaving; however, devitalization of vegetative bacteria can be attained rapidly through use of isopropyl alcohol in a practical way. This action amounts to clinical asepsis and not bacteriological sterility.[2]

## SUMMARY

When used for "cold sterilization," isopropyl alcohol appears to have antiseptic action adequate to produce practical clinical asepsis. Absolute bacteriological sterility, on the other hand, is an entirely different matter, and is not believed to be attained regularly with any usable chemical in the time allotted to "cold sterilization." The present report is intended to supply information based on controlled tests of a product used for many years with little available knowledge of extent of antiseptic action.

Staphylococcus aureus #209 referred to above is a well-known culture obtained from the United States Food and Drug Administration. The other cultures need no special notation of origin.

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## ABSTRACT

### CORRESPONDENT PICTURES HEALTH CONDITIONS IN FRANCE

A picture of health conditions in France during and after the European war is described by the Paris correspondent of *The Journal of the American Medical Association*, who said that "the infant mortality after the winter of 1944 was highest for this century."

In the August 25 issue of *The Journal*, the correspondent said:

"The number of deaths in 1939 exceeded the births by 29,000; the mortality rate was 15.5. Exclusive of the soldiers who died at the front, the prisoners and the deportees, it reached more than 18.0 in the course of the occupation and decreased to 17.0 in 1943. The infant mortality after the winter of 1944 was highest for this century. The morbidity followed the same trend. New cases of syphilis increased fivefold, typhoid fourfold and diphtheria threefold. Tuberculosis, amounting to 224 deaths per hundred thousand in 1930 and 172 in 1939, attained in 1942 the record figure of 234. There is a deplorable shortage of physicians, a catastrophic deficiency of nurses and social workers and lack of medicines. The number of hospitals is inadequate and their equipment is poor.

"The minister of health has announced projected reforms, but the needs are of such magnitude that best intentions run the risk of only partial fulfilment. . . .

"Medical education is to be improved; the preparation of the physician will be more methodical and better balanced. A more rigid control will replace the liberty formerly enjoyed by the students. A better distribution of physicians over the entire territory is likewise contemplated. At the same time the training of medical aids, particularly of nurses, will be improved, and their social status bettered. Control of physicians created on a new basis, and regulated by the physicians themselves, control of midwives, of dentists and of pharmacists will be the task of the professions themselves. . . .

"A check will be established against the 'fake' pharmaceutic specialties and the 'black market' in medicines."

*THE JOURNAL*
OF THE
INDIANA STATE MEDICAL ASSOCIATION
DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA
*Copyright. 1945, Indiana State Medical Association*

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**SEPTEMBER, 1945**

# Editorials

## V-J DAY

And what a day! One of those days we knew was ultimately coming, but one for which we had to wait. First, V-E DAY, followed in a short time by *THE DAY OF ALL DAYS.* This, because it means, for some years at least, a cessation of tyrannical government everywhere in this wide world. It means that War Lords, as such, are completely out of the picture; and, further, it means the end of the most fanatical government ever to exist on the face of the earth.

Mussolini and Hitler have gone, each dying an ignominious death. Only Hirohito remains, to be under the mailed fist of a man who knows the Japs for what they are—General MacArthur, and that man will know exactly how to handle the former Emporer.

So, again we have PEACE, and with every prospect of it being a *lasting peace.* We again can plan the normal way of life; we look forward to having our sons and daughters home with us, soon. And to the medical profession it means the early return of thousands of medical officers, the thing we need most right now.

It also means that the oldsters in the profession, men who have worked long hours and under trying circumstances, soon will be permitted to take a little rest; for some it means the first real vacation in many, many months. One might write columns about what V-J DAY means to every citizen of the nation—every citizen of the whole world, for that matter, but we will leave that to the professional writers. For us of the medical profession, we all know just what it means today, and what it will mean on the morrow.

Joining with the people all over the world, we can but say, "Thanks, Almighty God."

## ANNUAL MEETING

A week ago—August fifth—we sat in with the Executive Committee, in regular session, where the matter of plans for the annual meeting were being discussed. As was expected, the committee voted to call off this meeting in deference to an order from ODT refusing to issue any permits for such gatherings.

Although the end of the Pacific war will restore many things that have for many months been denied us, announcement comes from ODT that transportation problems will remain for some months.

Since the Executive Committee meeting was held, the war has ended, so application has been made for permission to hold the 1945 annual session. This was originally scheduled for October 2, 3, and 4, at the French Lick Hotel. If the ODT approves the session for this year, it probably will be for dates in November or December.

Difficulties will result if we are unable to hold an annual meeting. We have a Constitution and By-Laws which cover practically everything that comes before such groups, these instruments definitely set up certain procedures, and now the problem will remain unsolved as to how we can proceed until we have an annual session.

As gas rationing has ceased, it may be possible to hold a one-day session of the House, even though we do not have an all-out annual session. A two-day session may be impossible, since the housing situation will continue to be a problem for months to come, and our hotel facilities will continue to be booked well ahead.

So, for the nonce, whether we have our formal convention in 1945 or 1946, it is hoped that most of our service buddies will be back, and that we can make this a real postwar meeting, with papers by our own ex-servicemen, and with a meeting that will go down in medical history as being the best ever.

In the event that there are any changes in our plans, the membership will be notified immediately.

## OUR PRESIDENT

Neslen Kelliher Forster is a product of the great, wide open spaces, having been born in Missoula, Montana, December 30, 1892. His parents were

George M. Forster and Mary Cecile Forster, the former an attorney-at-law.

His educational record consists in attendance at the local public school, and graduation from the Gonzaga University, at Spokane, Washington, with the degree of A.B., in 1911, and M.A., in 1917. He received the degree Doctor of Medicine from the University of Illinois, in 1919. He served as an intern at the Michael Reese Hospital for eighteen months, and a similar period at the Cook County Hospital, both institutions being in Chicago.

He did postgraduate work at the University of Chicago Medical School in 1930-1933, and one year at the Northwestern University Medical School, in 1938.

The list of his medical society memberships resembles the volume of a bibliography of a long scientific article, and a list of the papers he has written would fill more than a column in THE JOURNAL.

His medical society activities have been many, over the years, and he has filled many offices in these societies. Locally, he has served as both president and vice-president, as well as headed many important committees. He served as editor of the *Lake County Medical News* from its inception until about two years ago, his work in this field attracting much atttention.

While enaged in general practice, his work in recent years largely has been industrial surgery, being employed by many Lake County industries.

In 1924 he married Ethel Welch. The Forsters have no children, but for some time have been looking after three nephews, ages five, seven, and nine. Each of these boys is, indeed, a rugged individualist and lead "Uncle Nes" a merry chase.

"Nes," as he is best known to his friends, has had a varied career, in that he has gone places and done things ever since he first learned to toddle. At one time he took a year of work at the Worcester Academy, Worcester, Massachusetts, in preparation for entry into the Massachusetts Institute of Technology. Later, moving to Los Angeles, he naturally drifted toward the cinema industry, working as a laboratory technician and, occasionally, as a "fill-in" on the movie stage. (Probably in Bill Hart's two-gun Westerns—Editor.)

That is the biography, as it relates to his early youth and manhood. But what of the man? Doctor Forster, as such, has lived a busy life. He likes work, but never has forgotten that a little play is the best tonic a physician can prescribe for himself; hence, takes regular, rather frequent vacations. An inveterate reader, he keeps well abreast of what goes on in modern medicine and surgery. He is an exceptional writer and makes good use of his talent with frequent representation in medical literature.

We never have detected anything about him that would lead us to suspect he has a hobby, such as most medical men possess. He stated that his only hobbies are reading and writing. Hunting and fishing seem to have played a very minor role in his life, and we never have noted, in the local sports press, any mention of low scores made by him in the ancient Gaelic game; in fact, we never have heard him mention golf.

He did at one time start what we thought might be a hobby, that of picking up stones all over the country and transporting them to his back yard, where he planned a real rock garden. However, since many of these stones were too heavy for Ethel to handle, the rock garden did not progress any too satisfactorily.

In Lake County medical circles Nes has done an invaluable work; he has been regular in his attendance at all meetings, and frequently has appeared on its programs.

As head of the Indiana State Medical Association he has done well and has been a faithful attender upon every occasion calling for his presence. His counsel has been found to be invaluable, just as we of Lake County have found it. In a most trying war year he has done a good job, and will turn the association affairs over to his successor in excellent shape.

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## A NEW CANCER "FOUNDATION"

*The New York Times* of August eighth carried a news story regarding the proposed cancer research hospital, made possible by a grant from the Alfred P. Sloane Foundation, this to be known as the Sloane-Kettering Institute for Cancer Research, the buildings to be erected at the site of the Memorial Cancer Center, in New York City.

A grant of four million dollars has been set aside for this purpose, one-half of which will be used for new buildings and equipment. The site is on East Sixty-Eighth Street, in the eastern metropolis. Alfred P. Sloane, Jr., chairman of General Motors Corporation; and Charles F. Kettering, vice-president and chairman of research for that organization, will be in active charge of the new project, although it is specifically announced that General Motors, of itself, will have no connection with the management. This program makes it certain that Memorial Hospital will now become the most modern cancer center in all the world.

In addition to the original grant, the Sloane Foundation will provide something like two hundred thousand dollars per year for the next ten years toward operating costs. Memorial Hospital plans the opening of a public campaign, in the near future, to raise an additional four million dollars for the cancer project. It also is provided that the management of this new hospital will be separate from that of Memorial Hospital, although both institutions will, of course, work together.

In a recent meeting both Sloane and Kettering

were definitely of the opinion that the application of scientific research, as now applied in American Industry, to some of our medical problems would result in many new solutions, and that it would seem that the new setup will provide just that.

Oddly, just when the entire world is being astounded by the "atomic bomb" it is announced that the same principles used in atomic research have been used in cancer research, in the hope that the same energy that activates these bombs may in some manner be applied to the cure of cancer.

Two general problems will be the goal of this new institution—the cause and cure of cancer. As stated in the article, "some day, it is hoped, it may be possible to develop a test which will show whether or not a person is susceptible to cancer."

The study group who will operate at the new hospital will not be confined to American physicians; already there are registered doctors from Brazil and some of the other South American nations, and it is expected that many will later come from the European area. As we have said, the completed setup will afford the greatest opportunity for such study to be found in the entire world.

This thing called "research," has done wonders for industry, as well as the arts; without the research laboratories the automotive industry would not have reached its present peak. The great oil industry for years has maintained a huge staff of highly-trained research workers, with the result that our gas-propelled transportation facilities are unequalled elsewhere in the world. And, we need but refer to the recently-proclaimed "atomic bomb," which it cost some two billion dollars to produce, and whose man-hours in research soar into astronomical figures. So, with the same facilities at the command of those in charge of this new venture in cancer study, we may confidently expect that from time to time announcements of discoveries of new theories and new methods of treatment will be forthcoming.

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# Editorial Notes

Dean Gatch, in a personal letter to the editor, printed elsewhere in this issue, directs attention to a most vital matter, that of the desperate need for the return of a large percentage of the staff of the Indiana University School of Medicine. As he points out, the older men of the faculty have been carrying the entire burden for a long time—too long for many of them—and some measure of relief is now necessary. We trust that every member will do what he can to relieve the situation—a letter to *your* Congressman will help a lot.

Sporadic outbreaks of infantile paralysis are noted in the country, one of the worst being at Rockford, Illinois, where desperate measures are being taken to control the situation. It has been suggested that airplanes be used to "spray the whole city" with one of the newer solutions. A call has been sent out for graduate nurses to work there during the emergency, and oxygen outfits and "iron lungs" are being loaned for use in the local hospitals.

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An article in *Collier's* magazine, July twenty-fourth, makes the statement, under an editorial entitled "German Doctors under Naziism," that Colonel Edward D. Churchill, of the Allied Mediterranean Forces, acting as consulting surgeon therein, made a survey of six German hospital areas, concluding that "German handling of wounded was about twenty years behind that of the American procedure." And Germany, be it remembered, has had state medicine for many years.

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Now that censorship has been waived in practically all of the former war centers, the letters we get from our youngsters will have an added interest. We are dying to know some of the intimate details of life on Okinawa, for example, and expect that information to be coming through most any day. The boys will be telling us first-hand stories of what they have done and what they have seen, and we will get a composite picture of the folks we have been fighting.

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After waiting fifteen months for a favorable turn in events, we find ourself preparing for a trip to Canada, there to play with the Chippewa Indians of western Ontario. The Canadian woods, in September, offer many charms not noted earlier in the year, and the cool nights make for a slumber such as we do not have at home. Mac, Buck, and the writer are "headin' north," most any day now, awaiting only the preparations that it is necessary to make for such a trip. We plan to take the portable, hence, you will be hearing of the progress we are making on the unexpected vacation trip.

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For about the third time this summer we have received a plea for "Boys Camp" help, from an organization in New York City. Two of these letters contained what is purported to be an original application for admission to this camp. We are great believers in such camps for the "underprivileged boys of our cities; two weeks or so at one of these camps will do much for these youngsters, many of whom never have seen the open country. However, New York City has no monopoly on underprivileged boys; each sizeable community has such problems, and we have them right here in Indiana. Why, then, should we send money one thousand miles away to look after their boys? It is a local problem, and their local camp organizations should look after their own boys.

Garden talk is necessarily short, as there is little to talk about. For some unaccountable reason this has been a slow-growing season here in the Calumet area—even the old-time truckers admit they have not seen anything like it in recent years. The early plantings did very well, but tomatoes, peppers, corn, and what-not are very slow. The weeds, however, are doing exceptionally well; we manage to keep abreast of every one we know in that regard. When bigger and better weeds are grown, they may be had at 14 Ruth Street, Hammond.

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Down in New Harmony, Indiana, lives a quaint chap, a philosopher of the first water, C. L. Chaffin. He conducts a column in the *New Harmony Times*, a most readable column, under the heading "Club Notes."

In a recent column he offers a solution to a medical problem having to do with the required premarital blood tests. He says, "Anyone planning to get married can get a real blood test without having a doctor tap his arm. Just sit out on the porch and let one of those Wabash mosquitoes fill himself up. All you have to do is to wring the mosquito's head off and drain the blood into a bottle, and it's ready to be tested."

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*Steel Facts*, monthly publication of the American Iron and Steel Institute, is responsible for the statement that the reconversion of the steel industry to peace-time business will cost more than two hundred million dollars. The reconversion process will, of course, be carried on over a long period of time, much depending on just how rapidly the federal war agencies grant approval for the proposed changes. The steel industry, as everyone knows, has done a marvelous job of taking care of such a monumental task, their output during the war years being the greatest in the history of the industry. Those not living in close proximity to the steel-making centers can not conceive what has been done in the production of these war-time necessities.

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We just can't keep up with the Fishbein tribe; that is all there is to it, meaning in the matter of wartime grandchildren. In his column, "Tonics and Sedatives," Doctor Fishbein comments on how many such youngsters he has in his home. We have a sizeable kindergarten of war babies ourselves, and for a time thought we were in a fair way to catch up with the Fishbein tribe, when William Carwile came along, a month or so ago, making the score four. William, incidentally, is the third child to be born to Doctor Jim and his wife. But, lo and behold, comes the announcement of a fifth member of the Fishbein outfit, so we temporarily throw in the towel and admit defeat in this enterprise.

Comes now the end of gas rationing and the doing away with "blue points." The former never has bothered us a great deal, but the blue-point situation has caused us much concern. With our fifty points per month we could but longingly *look* at a large-size can of "Raggedy Ann" peaches—too many other things called for the blue points. Now we can go into the grocery and buy canned things that for a long time have been out of our personal picture.

We also are advised that points will be reduced on some meats, and eventually discarded altogether. We may even see the day when we can again be "choosy" about the cuts of meat we buy!

We are not throwing away our ration books, even after this is all over. They will go into the "memory chest," that our grandchildren may look at them in later years, and wonder what they meant.

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Within a few months Hoosier doctors will be sporting new automobiles, since most manufacturers have opened their production lines. Doctors, in most cases, will have a high priority, and most of the cars now in use will soon need replacement.

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The following report of the Federal Grand Jury, at Muskogee, Oklahoma, dated June 26, 1945, has been called to our attention by H. V. Darnell, executive secretary of the Indiana Pharmaceutical Association, and is reprinted from the *Indiana Pharmacist*. Since the report apparently also reflects the policy of the Federal Narcotics Division, it behooves all physicians to take notice, and assist in the cessation of such practice.

"We also beg to report that we have made a partial investigation of a report concerning laxity in the dispensing of narcotics by some of the medical profession and some of the druggists. The facts developed disclosed a rather shocking disregard of the law. In some instances it appears now that some druggists fill telephone prescriptions for narcotics and later take the prescriptions to the doctor for his signature. It also appears now that an unnecessarily large quantity of narcotics is being dispensed by some druggists and physicians to persons who are well-known addicts. The investigation thus far reveals an astounding condition in this respect. We do not wish to place ourselves in a position of attempting to determine when or under what manner, or in what quantities a person may need narcotics for the alleviation of pain or suffering, but we feel that we are in position to say that the conditions above-referred-to are intolerable and wholly unwarranted, and if continued can only result in an indictment wherever warranted. It has been stated in defense of this condition that the doctors are overworked and prescriptions by telephone are time savers. We are conscious of the overworked condition of most of our physicians, but we disagree with the contention that such practice is warranted in order to save time. It is a matter of obeying or violating the law.

"We are making this report at this time in the hope that these abuses, as well as any others not mentioned herein, may be speedily corrected. We propose to pursue this investigation further when next called, and will then take such action as the facts and circumstances warrant at that time."

# President's Page

## THE COMMITTEE REPORTS

The fundamental basis upon which any organization can function properly lies in the quality and ability of the members who serve on its various committees. This is true of our association, as it is of all others. None of the problems that are constantly arising can find solution except through careful consideration, discussion, and recommmendation by a group of representative members designated to deliberate such questions and present their findings for the action of the organization as a whole.

Wartime has placed an exceedingly heavy burden upon the shoulders of the men who make up our many committees. Not only have they had to contend with the additional responsibilities of practice, but they have also been asked to devote time, that might well have been spent in rest, to the attendance of meetings and in lending their assistance to the preservation of an active, progressive, and sustaining organization.

Their labors are reflected in the pages of this issue of THE JOURNAL, for represented here are the results of hours and days of work in assembling conclusions for the welfare of all of us.

Time was when the appointment to a state committee represented an honor that entailed very little work, an empty recognition, perhaps, of long service in medical practice, or a friendly gesture. This is not true today because such an appointment carries with it not only the recognition of ability, but the confidence and hope of the entire organization and the knowledge that the problems to be considered will require a definite amount of personal sacrifice.

We are fortunate in having in our ranks men who do not shirk the responsibilities of these committee tasks, and who have answered the need by a splendid, cooperative, and willing response. Your attention is directed to their reports, and it is sincerely hoped that every member will read them.

The restrictions of wartime travel and the ban upon conventions have brought about the necessity for cancellation of our annual meeting. We share this disappointment in common with all other organizations, but it can only make us more determined to build for the future in anticipating the time when we will meet again.

The special meeting of the House of Delegates to consider the report from the Committee on Prepayment of Medical and Surgical Care will be called within a short time. The regular meeting of the House of Delegates has been made subject to call, dependent upon restrictions and available dates. It is hoped that both these meetings will be possible, and, in order that the business to be considered may be handled with dispatch each delegate should thoroughly familiarize himself with the committee reports, and, in addition, be prepared with the viewpoint of the county society he represents so that he may effectively discharge his duty. The future direction of medical thought, so far as our organization is concerned, lies in the hands of our delegates. It is their responsibility to speak for the welfare of the Indiana State Medical Association, and to guide its destiny. The privilege is a holy one.

N. K. Forster

# FUTURE TRENDS IN MEDICAL PRACTICE *

LIEUTENANT COLONEL HAROLD C. LUETH, M.C.

Formerly Surgeon General's Liaison Officer to The American Medical Association

CHICAGO, ILLINOIS

At the outset I wish to remind you that my remarks are not to be construed as official opinions of the Surgeon General or the War Department. They are simply some purely personal observations that have been acquired during the past few years, as a member of the American Medical Association.

For some time it has been of concern to members of the American Medical Association, particularly the Council on Medical Education and Hospitals, that thought be given to the problem of postgraduate medical training for returning medical officers. After conferences there was established by the American Medical Association a Committee on Postwar Medical Service in collaboration with the American College of Physicians and the American College of Surgeons. The Joint Committee, in an exploration of the probable educational needs of veteran medical officers, authorized the formulation and distribution of a pilot questionnaire to three thousand medical officers on duty with the armed forces. The questionnaires were mailed to every fifteenth name on an alphabetical list of all officers on duty with the Army, Navy, and Public Health Service, in the belief that a fair sample was obtained. The number of returned questionnaires indicated that information was returned from nearly every area in the world to which our troops in numbers are on duty. A report of the results of the first one thousand returned questionnaires was published in *The Journal of the American Medical Association*, of August 19, 1944.[1] One thousand questionnaires were reviewed from an educational point of view. Questionnaires were divided into six groups for study, on the basis of date of graduation from medical school. Dates of graduation were better indexes than age of medical officers in determining the kind of medical education desired. Group I consisted of those graduated from 1941 to 1943, inclusive; Group II, the graduates of 1938 to 1940, inclusive; Group III, the graduates of 1935 to 1937; Group IV, graduated in 1930 to 1934, inclusive; Group V, graduates of 1920 to 1929; and Group VI, those graduated prior to 1920. In each group there was the following number of officers:

| Group No. | Years of Graduation | Desire No Educational Courses | Desire Six Months or Unspecified Period | Desire More Than Six Months' Training | Total | Per Cent |
|---|---|---|---|---|---|---|
| 1 | 1941-1943 | 4 | 41 | 119 | 164 | 16 |
| 2 | 1938-1940 | 21 | 38 | 148 | 207 | 21 |
| 3 | 1935-1937 | 39 | 82 | 69 | 190 | 19 |
| 4 | 1930-1934 | 63 | 79 | 80 | 222 | 22 |
| 5 | 1920-1929 | 60 | 82 | 38 | 180 | 18 |
| 6 | Before 1920 | 17 | 16 | 4 | 37 | 4 |
| | Total..... | 204 | 338 | 458 | 1,000 | 100 |

NOTE—This table refers to number of officers, and not to number of courses. All the following tables give the number of courses, and not the number of officers.

Questionnaires were carefully analyzed in an effort to obtain as much information as possible concerning future medical educational plans. Some men requested courses in several subjects. Each request for a course of instruction in a special field of medical practice was tabulated except when a request was made for more than three different subjects in a short period of time. The latter were entered as requests for general courses. All requests for refresher, "brush-up" and review courses or "visiting clinics" were also tabulated as general courses.

Educational requests were made for varying periods of time. An average was used when requests for two periods were made. For example, requests for six to twelve months or one to three years were counted as one nine-month course and one two-year course, respectively. Consequently there were more requests for courses than officers in some groups.

Each group was subdivided into three sections, depending on the amount of training that was requested:

(a) *No Further Training:* Officers who desired no future training or who failed to answer that part of their questionnaire were considered as one section.

(b) *Review Courses:* Men who requested a specified time up to six months were considered as those desiring review courses, and were thus classified. In addition, men who did not give a definite time of training and from whose questionnaires it appeared they desired a short future course were also grouped as requests for review courses.

(c) *House Officerships:* The third section comprised those men who expressed a desire for definitive training of more than six months, that could be considered as residency or fellowship training.

* Presented before the Secretaries' Conference of the Indiana State Medical Association, at Indianapolis, on January 21, 1945.

[1] Lueth, H. C.: Future Education Objectives of Medical Officers, *J.A.M.A.*, **125**:1099-1103, (Aug. 19) 1944.

Questionnaires from men whose residency was interrupted by an early call to military duty and who requested "time enough for completion of board" were marked as requests for one or more years of study, depending on the amount of residency.

A review of the six groups showed the following significant results:

### GROUP I
### (Graduates of 1941 to 1943)

Nearly all recent graduates came directly from house officerships to the military services. Only a few did not want any additional educational training.

*Men Who Want Six Months or Less of Future Education:*

More than one-fourth of the graduates of 1941 to 1943, inclusive, desired a future training course of six months or less. Many came directly from internship, and others came from a residency. Requests for short courses were mainly for six-month courses, but a few did not specify the time they desired to utilize for educational purposes. There were requests for courses in the following specialties: Internal medicine, surgery, general courses, and other fields.

*Men Who Want More Than Six Months of Future Training:*

More than two-thirds of the recent graduates in Group I desired quite extensive educational courses. There was a total of 119 men, of whom 99 entered the armed forces directly after internship, and 16 directly after residency. There were 29 requests for a one-year course of study, 55 requests for a two-year course, and 57 requests for three or more years of study. The following number of requests were made for the following specialties: 52 for surgery, 28 for internal medicine, 20 for obstetrics and gynecology, 11 for general, 5 each for pediatrics and orthopedic surgery, et cetera.

### GROUP II
### (Graduates of 1938 to 1940, Inclusive)

*Medical Officers Who Do Not Desire Any Additional Training:*

About ten per cent of the Group II graduates failed to indicate any desire for additional training. Most of the men came from hospital service or practice. About one-half of the men (11) were actually engaged in some practice—6 in special practice, 3 held full-time positions, and 2 were in general practice. The American Board had certified three of the men in special practice, and two had received partial certification.

*Men Who Want Six Months or Less of Future Education:*

About two-thirds of the graduates of 1938 to 1940, inclusive, desired definite future educational training courses. There were 148 medical officers in the section who wanted six months or more of training. About one-half of the men came into the service directly after internship (32), or residency (40). The men who came from practice were: in general practice (26), special practice (16), and full-time medical practice (11). Requests were mainly for one- and two-year courses.

### GROUP III
### (Graduates of 1935 to 1937, Inclusive)

About twenty per cent of the officers in Group III either did not desire additional medical educational training or left their questionnaires blank concerning future plans. Most of the men were in special practice before they entered duty, and the remainder were in general practice. About one-fourth of the section (10) were certified by an American Board, and two others of the section had been partially certified.

*Medical Officers Who Desire Six Months or Less of Future Education:*

A group of 82 medical officers, or half the officers in Group III, signified that they desired some future medical educational training of six months. About half of the section were in general practice (49) and the other in special practice (33) before they entered military service. About one-fourth of the entire section, or half of those engaged in special practice, had been certified by an American Board. Short general medical courses were desired by a majority of the men. Requests were made for courses in the following specialties: internal medicine, obstetrics and gynecology, surgery, general, ophthalmology, pediatrics, psychiatry and neurology, and other fields.

A variety of answers was given as to the location at which instruction was to be given. Requests varied from specific institutions, such as the Massachusetts General Hospital, the Presbyterian Hospital of Chicago, and University of Minnesota, to cities and to general geographic locations, such as a midwestern or eastern city.

*Medical Officers Who Want More Than Six Months of Future Training:*

One-third of the officers in Group III expressed a desire for long periods of study. In the main, the requests were for residencies or hospital fellowships. A few of them signified the desire of one-year senior internships, to be followed by suitable residency and then a period of intensive training in a specialty. A great number of these men were in general practice (38) before entering the armed forces. There were eighteen in special practice, of whom eight had been certified by the American Board, and one was in the process of certification. Training was desired mainly in surgery, internal medicine, general, ophthalmology, and obstetrics and gynecology.

### GROUP IV
### (Graduates of 1930 to 1934, Inclusive)

*Men Who Do Not Desire Any Future Medical Training:*

More than one-fourth of the officers in Group IV (63) did not desire any additional training. There were 43 men engaged in special practice before they entered active duty, and 13 in general

practice. About two-thirds of those in special practice were certified by an American Board. It was not surprising that this section of men do not desire any additional training, since more than three-fourths of them indicated a strong desire for an early return to private practice.

*Men Who Desired Six Months or Less of Future Education:*

A group of 79 officers, or more than a third of Group IV graduates, comprised this second section. A training period of three months or less was desired by one-half of this group. This section was about equally divided between general practitioners (32), and specialists (35). Training was desired in about the same fields as for similar sections in Groups II and III. About one-half of the men named a definite training center or hospital.

*Men Who Want More Than Six Months of Future Training:*

A total of 80 officers requested additional training in excess of six months. There were 43 who were formerly in general practice, and 33 in specialty practice. Most of the men wanted either one or two years of further training. The courses desired were as follows: surgery, ophthalmology, otolaryngology, internal medicine, general, and obstetrics and gynecology.

### GROUP V
### (Graduates of 1920 to 1929, Inclusive)

*Men Not Interested in Additional Educational Training:*

An analysis of 60 men in Group V who were not desirous of having additional training, or undecided in the matter, was undertaken. Thirteen of the section were in general practice, 2 held full-time positions, and the remainder (45) were in specialty practice. Further analysis showed that there were 36 men in the section who have specialty board certification.

*Men Who Desire Six Months or Less of Future Education:*

A future educational program of six months or less was selected by 82 men, or about half the section. Graduates of 1925 or later represented a majority of the section. Requests indicated that a three- and six-months' course were favorite choices. Forty-five of the section had previously been in specialty practice, of whom 18 were certified by American Boards. There were 27 men formerly in general practice. Nearly all requests were for a review or refresher course. Future training was requested in the following specialties: internal medicine, surgery, general, ophthalmology, obstetrics and gynecology, dermatology and syphilology, and pediatrics.

*Men Who Want More Than Six Months of Future Training:*

There were 38, or about one-fifth the section, of whom about three-fourths graduated after 1925. Eleven had been in general practice before their entry into the armed services, and 15 in special practice. A one-year training course was requested by 25 officers. The following specialties were selected: internal medicine, surgery, general, otolaryngology, obstetrics and gynecology, psychiatry and neurology, and other fields.

### GROUP VI
### (Graduates Prior to 1920)

The oldest and smallest group consisted of 37 officers, 17 of whom did not desire any additional training. There were 16 men who requested 19 courses of six months or less, among whom 6 specifically asked for general courses. Four officers requested one-year courses. Two requested courses in surgery, 1 in pathology, and 1 a general course.

Soon after the first results of the pilot questionnaire were analyzed, the Committee on Postwar Medical Service decided to prepare a revised or final questionnaire that was to be sent to each medical officer on duty with the Army, Navy, Public Health Service, and Veterans Administration Facility. The questionnaires were mailed to naval medical officers in June, soon after the annual session of the American Medical Association. The Division of Personnel of the Bureau of Medicine and Surgery, United States Navy, had an addressograph plate for each naval medical officer, so that the distribution of the questionnaires was accomplished within a few weeks. Due to certain unfortunate delays questionnaires were not mailed to the medical officers of the Army until some time later, and to the medical officers of the United States Public Health Service early in September. Returns from medical officers have been excellent, and at present more than 23,500 questionnaires have been received. Reports[2, 3, 4, 5] have been made on more than 21,000 questionnaires.

A comparison of the results of requests for courses as shown by the returns of the first one thousand pilot questionnaires and the final questionnaires was very revealing. There has been an increased desire to take long courses. The final questionnaires showed a slight increase in the number of requests for long courses. Compared to the pilot questionnaire, it appeared from the final questionnaire that about 20 per cent more younger men wanted longer courses. More recent graduates with a nine-month internship are being called to early military service as the war continues. Consequently, there will continue to be an increased desire by younger medical officers for longer periods of hospital training after the war.

Drs. Victor Johnson and F. H. Arestad, secretary and assistant secretary, respectively, of the Council of Medical Education and Hospitals of the

[2] Lueth, H. C.: Postgraduate Wishes of Medical Officers: Final Report on 21,029 Questionnaires, *J.A.M.A.*, 127:759-770, (March 31) 1945.

[3] Lueth, H. C.: The Medical Officer Returns to Civilian Practice, *J.A.M.A.*, **127**:1039-1043, (April 21) 1945.

[4] Lueth, H. C.: The Medical Officer and Future Industrial Medical Practice, *J.A.M.A.*, **128**:93-94, (May 12) 1945.

[5] Lueth, H. C.: Economic Aspects of Future Medical Practice, *J.A.M.A.*, **128**:528-529, (June 16) 1945.

American Medical Association, have prepared a questionnaire that has been mailed to the hospital superintendents of each approved hospital, to determine the extent to which hospitals can enlarge their facilities for future postgraduate training. On the basis of preliminary estimates[6] they have found that if hospitals can double their existing facilities they will be able to take care of the returning medical officers. It is possible that some six hundred to one thousand approved hospitals will seek to participate to some extent in furnishing hospital training to returning medical officers.

Hospitals and medical schools will find their existing facilities strained considerably in their efforts to give twice as many men training as they formerly accommodated.

Financial aid to men during the period they are engaged in postgraduate studies has been considered. A recent interpretation of *Public Law No. 346*, 78th Congress (G. I. Bill of Rights), defines the financial benefits to be given returning medical officers. A full statement of these benefits were described[7] in the sub-committee report to the Committee on Postwar Medical Service, as prepared by Drs. F. A. Coller, Walter W. Palmer, and Father Alphonse M. Schwitalla. Some have proposed the use of private endowments, funds, or other sources to assist these officers who do not come within the scope of the Veterans' Benefits.

A means of providing additional assistance to veteran medical officers was frequently discussed by members of the American Medical Association. Following these discussions, the House of Delegates, at its 1944 annual session in Chicago, created and authorized the establishment of a Bureau of Information. The reference committee appointed to investigate the subject reported:

". . . the establishment of a Bureau of Information in the Central Office in Chicago, and likewise the effort to stimulate the state and county societies to establish local offices which are to cooperate with that bureau in bringing the necessary information to those who desire it. This central bureau might also serve the purpose of affording practitioners of medicine the opportunity for locating in new communities, and this matter should be given adequate publicity. . . ."

The Bureau of Information is an active part of the American Medical Association. Its primary aims are:

1. To provide veteran medical officers with information concerning educational opportunities immediately after their term of military service.
2. To provide veteran medical officers with information concerning medical, social, economic, financial, and other phases of community life that will enable them to make a wise selection of a permanent location in which to practice medicine.
3. To provide veteran medical officers with information concerning state licensure, and facilitate their procurement of licensure in states other than the state of former practice and/or licensure.

A summary of the important functions of the Bureau of Information include the following (a more complete description of the activities of the bureau has been previously published[8]):

(1) *Information on Medical Education:*

In general, men in the older age brackets desired refresher courses, while younger men desired resident training of one to three years.

Throughout all these studies, the Council on Medical Education and Hospitals, of the American Medical Association, has been most cooperative and helpful. The possible enlargement and extension of civilian hospital training facilities are being determined by a careful statistical study of the returns from Doctor Johnson and Doctor Arestad's questionnaires.

The Bureau of Information is appreciative of the assistance of the Council on Medical Education and Hospitals, and will continue to work in close harmony with it. The Council on Medical Education and Hospitals will place at the disposal of the returning medical officers all of its available information as to existing hospital and medical school facilities. An inventory of all hospital training facilities will be kept up to date by the Council, so that the veterans can at all times be informed of existing vacancies. Men returning from the armed services will want to be placed in an educational institution as soon after their release from military duty as possible. It is extremely important that some central routing agency have available current trustworthy information. There is every indication that the Council on Medical Education and Hospitals, and especially the staff members at the association headquarters, will be most helpful to the bureau in this phase of its activities.

(2) *Information on Licensure:* The Bureau of Legal Medicine and Legislation has been very helpful in supplying information concerning state laws in regard to licensure. There have been many inquiries from medical officers, both on duty and released from military service, concerning eligibility for licensure in states other than those in which they were originally licensed to practice medicine. There is reason to believe that there will be changes in some states relative to reciprocity and licensing of veteran medical officers. Mr. J. W. Holloway, Jr., director of the Bureau, has given prompt information on all such inquiries, and he has done much to help the Bureau of Information in the integration of the efficient machinery of his bureau with that of the Bureau of Information in meeting these problems.

(3) *Information on Medical Practice:* The most important work of the Bureau of Information is in supplying the individual medical officer with information concerning medical practice in various

[6] Johnson, V., and Arestad, F. H.: Educational Facilities Required for Returning Medical Officers, *J.A.M.A.*, **126**:253-257, (Sept. 23) 1944.

[7] Coller, F. A.; Palmer, W. W., and Schwitalla, A. M.: Graduate Education of Physician Veterans under G. I. Bill, *J.A.M.A.*, **126**:709-711, (Nov. 11) 1944.

[8] Lueth, H. C.: The Bureau of Information—Its Functions and Operation, *J.A.M.A.*, **127**:33-36, (Jan. 6) 1945.

communities. The Bureau of Information is not a placement agency; it is not an employment agency. The Bureau of Information is an entirely voluntary agency without any power to direct the location of a physician. It can, however, give invaluable assistance to the veteran medical officers in enabling them to make a wise selection of a community in which to practice medicine. To this end, a summary sheet was prepared that will give the returning medical officer a "thumb-nail sketch" of the community.

### INQUIRIES

Inquiries addressed to the Bureau of Information will be handled according to the nature of the inquiry. All inquiries concerning further hospital training of veteran medical officers will be referred to the Council on Medical Education and Hospitals for assistance in framing replies. Inquiries concerning licensure will be referred to the Bureau of Legal Medicine and Legislation for information on which to base a reply. Copies of such replies from the Bureau of Information will be forwarded to the offices of the state medical societies concerned.

Inquiries concerning placement or suitable locations in which to practice medicine will be referred, for solution, to the interested state medical societies. It is contemplated that an individual reply will be sent by the Bureau of Information to all medical officers requesting assistance in the selection of a location in which to practice, telling them that definite information can best be obtained from the secretary or executive secretary of the state medical association. A copy of the summary sheet for the county will also be inclosed, so as to give the inquirer an outline of the pertinent facts concerning the community under consideration. Carbon copies of the replies to inquiring veterans will be forwarded to the appropriate state medical association officers for their information and guidance. It is hoped that the state medical societies will enter the problem at this stage of development and initiate correspondence directly with the men.

The county was chosen as the unit, since there is considerable information readily available about the counties of the United States. Information concerning the counties will be entered on cards and retained in the files of the Bureau of Information for future use. When an inquiry is made concerning a county, a member of the staff will withdraw the County Information Sheet and type the information on a mimeographed sheet. In addition, an individual reply, as described, will be mailed to the veteran together with the summary sheet.

Copies of the County Information Sheet will have been previously mailed to each state medical association for its use. It is expected that the state and county medical society officials will review the summary sheets very carefully and make all necessary corrections and additions. A copy of the corrected county summary sheets should be returned to the Bureau of Information at the earliest possible time.

### COUNTY INFORMATION SHEET

A form that will include pertinent information concerning the medical, hospital, economic, financial, climatic, social, and other conditions of the county was prepared. Mimeographed sheets have been adopted as a summary of information that will be helpful to the returning medical officer.

It is difficult to determine the exact size of a community in relationship to medical practice. After all the factors involved were considered, the county was chosen as a representative unit since there is considerable information readily available about counties. It is, of course, appreciated that there are many difficulties in utilizing the county as a unit, particularly in metropolitan and suburban medical practice. However, for purposes of uniformity and record keeping the county was the unit chosen.

A sheet was prepared for each county of the United States, giving as much specific information concerning the county as would be of practical assistance to the discharged medical officer in making his selection of a location to practice medicine. The heading of the sheet contained the name of the county and state, and the names of state and county medical society officers, with their addresses. The body of the information was divided into two parts, the left-hand side being devoted entirely to the medical aspects of the community:

(I) *Medical Information.*

It contained the following subject heads:

a. Hospitals.
b. Public health facilities.
c. Other medical facilities.
d. Physicians.
e. Remarks.

(II) *Economic, Social and Financial Information.*

(A) General Statement: Under the heading of "General Statement" this unfinished sentence appears: "This county is largely . . . ." It is requested that state and county medical society officers fill in such terms as industrial, agricultural, mining, or give a short description of the activities of the community.

(B) Location and Climate: A few sentences concerning the general location and the average climate of each community, as determined by the United States Weather Bureau, will be entered under this heading.

(C) Population: All population data were obtained from the Bureau of Census. The 1940 population was given first, since that is the latest decennial census. It was also assumed that 1940 was an index of the prewar status of the communities of the United States. Since the war began there have been great shifts in population, so that the estimated 1943 census was entered directly under the 1940 census. A comparison of these two figures reveals the change in the community, resulting from wartime shifts in population.

(D) Principal Cities: The principal cities were listed by name together with their population.

(E) Schools: The number of elementary, secondary, and parochial schools, and colleges and universities will be entered under this heading.

(F) Retail Sales: From previous studies it was shown that total retail sales were an indication of the wealth of the community. A special study of the distribution of physicians in the state of Wisconsin, by Mr. C. F. Deibler and Lieutenant Colonel Harold C. Lueth, revealed that retail sales were a good index of the wealth of the community. The total retail sales in thousands of dollars for 1943, as estimated by Sales Management, were listed under this subhead. This first entry perhaps may be large and confusing to the average doctor, so a second entry of county sales per capita was made to give a comparison between a county and the state as a whole. State sales per capita were listed thirdly.

(G) Residence Telephones: The number of residence telephones in 1940, both by county and by state, was recorded from data furnished by the American Telephone and Telegraph Company.

(H) Miles of Highway: The number of miles of highway for county and state, as given by the state highway commissions, was entered under the next subhead.

(I) Dwelling Units in County: Some features of the social and economic life of the community may be determined by the number of dwelling units in the county. The total number of dwelling units in 1940, as provided by the Bureau of Census, was entered. A second entry showed the number of dwelling units occupied by the owner. The third entry was the average monthly rental, including urban and rural non-farm buildings.

(4) *Operation of the Bureau of Information:* The successful operation of the Bureau of Information is dependent on the active cooperation and close harmony with the state and county medical societies. Inquiries from medical officers to the Bureau of Information will be answered promptly. Inquiries concerning educational and licensure problems will be answered by coordinating the information of the several departments at the headquarters of the association. Inquiries concerning location and medical practice will be acknowledged by the Bureau of Information, and a copy of the County Summary Sheet forwarded to the medical officer. A carbon copy of the reply of this office will be forwarded directly to the state medical society for further handling. It is anticipated that state medical society officers will continue the correspondence with the man and assist him in placement in a suitable location.

The Bureau of Information is a new department of the association. It is capable of giving a new type of service to fit the needs peculiar to returning medical officers. The success of the Bureau of Information is directly dependent on the support and cooperation of the state and county medical societies. Ever since the founding of the American Medical Association the profession has prided itself in the amount of unselfish service it has given. The successful operation of a Bureau of Information entails a great amount of painstaking clerical work on the part of many members of state and county medical societies concerned with its operation. To give this new and useful type of service to returning medical officers is a real contribution. To assist returning veterans in selecting a location is a new service that medical societies can give. Repeatedly, it is said that medicine "can keep its own house and manage its own affairs." The successful operation of the Bureau of Information presents a real challenge to all of us to prove our ability to provide for our own.

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## ABSTRACT: MOSQUITOES CAN TRANSMIT SLEEPING SICKNESS TO HUMANS

One of the common American mosquitoes—Culex tarsalis—has been found guilty of carrying encephalitis to human beings.

Evidence to support this fact was obtained by four investigators, W. McD. Hammon, M.D., W. C. Reeves, Ph.D., and Bernard Brookman, A.B., all of San Francisco, and S. R. Benner, M.D., of Yakima, Washington, who report the results of their study of the annual epidemics of encephalitis in the Yakima Valley, Washington, in the August 18 issue of "The Journal of the American Medical Association."

Various forms or types of encephalitis are recognized by medical science. All are caused by disease agents or viruses which attack the central nervous system. Popularly known as "sleeping sickness," this virus disease usually causes the patient to become lethargic or sleepy. Convulsions and paralysis sometimes accompany the somnolence or lethargy, and in many cases there is a delirium in which the patient may have emotional outbursts, delusions, or periods of depression. Unfortunately, scientific medicine has not yet developed any specific method of treatment that will prevent this disease or arrest its progress.

The peak of the Yakima Valley epidemics, which occurred in 1939-40-41-42, was reached during the middle and latter part of August. Studies of the numbers of mosquitoes showed that the activity of the Culex tarsalis mosquito paralleled the epidemic curve. The authors explain that "the period of greatest activity of several species, including Culex tarsalis, just preceded the peak in onset dates of human cases, a period representing probably the incubation period in man and mosquito." The incubation period is the duration between the time the virus is introduced into the body and the appearance of visible symptoms.

"During July and August," the authors report on their 1942 study, "a total of 24,751 mosquitoes, including nine species, were collected and tested for virus content, yielding forty-nine strains of virus. Of these mosquitoes 9,466 were Culex tarsalis. A total of forty-five viruses was isolated from this species, forty-one western equine and four St. Louis strains. Thus, an infection rate was demonstrated in Culex tarsalis of at least one in each 210 collected, as compared to one in each 386 found the preceding year. The role of Culex tarsalis as a natural vector of these viruses in the Yakima Valley is thus amply confirmed."

Collections of mosquitoes were made on the horse, cow, and man to determine which of the various mosquito species fed on these animals. It was found that Culex tarsalis fed frequently on birds and included most of the common domestic animals in its feeding range. The results of laboratory tests, and the repeated isolations of the virus from this mosquito give strong support to the probability that domestic fowl are an important "reservoir" of infection in the Yakima Valley.

# NEW MEDICAL CARE PROGRAMS AND THE AMERICAN MEDICAL ASSOCIATION*

R. L. SENSENICH, M.D.

SOUTH BEND

New medical care programs cannot be discussed intelligently without giving some consideration to what we now have, the factors that have influenced progress to this point, and what needs are to be met. For that reason a brief survey of the situation should be helpful.

The best possible medical care for all the people has been the constant aim of the medical profession of the United States throughout the years. The present standards of medical care in America are higher than in any other country in the world.

The remarkable achievement of present high standards of medical education and medical care has been accomplished by the profession itself. The American Medical Association and its constituent and component societies have provided the means for study and action to this end. The individual would be helpless. The uninformed public, the economic planner without experience in giving medical care, and the politically-minded public official could be more harmful than helpful. In fact, higher standards of medical education, advancement of scientific medicine, improvement of hospitals and medical equipment, and evaluation of new drugs and techniques have been accomplished by the councils of the American Medical Association and by its constituent state associations against indifference in government circles.

Medical service in illness, preventive medical measures, attention to nutrition, and immunization in childhood, through education and voluntary efforts, is more advanced in the greater portion of the United States than in comparable European groups having compulsory sickness insurance plans.

The medical profession has been justly proud of its cooperation with all agencies, governmental and private, in giving medical care to those in need of care and unable to pay for that service. Services and medicines to the sum of many millions of dollars have been given without charge by physicians each year without public statement or record. No one in need of medical care, and making that need known to the proper officials of government or private agencies, or directly to physicians, should have failed to receive medical service. An inquiry concerning this matter was addressed by the American Medical Association to public officials and charity agencies of towns and ministers of local churches and other citizens in smaller areas throughout the United States. Only a few instances of inability to obtain needed medical care were reported, and the reasons for these failures were not clear. Others who should have had medical care may not have sought it because of the cost.

Although the number of these is apparently not as great as is often estimated, the American Medical Association is interested in determining the causes of these unnecessary hardships and in assisting in correcting them.

It is recognized that certain areas do not have physicians or medical facilities in which good medical care could be given. Sufficient education in matters of health is often lacking, and services which might have been helpful are not sought. There are no available facts from which any approximation may be made of the actual effect of this deficit upon the health of the public in these areas, other than the prevalence of nutritional disorders and of communicable disease—notably tuberculosis and syphilis.

The American Medical Association began years ago to study the needs for medical services and the inadequacies of medical facilities. Roughly, the subject may be considered under four subdivisions:

I. Provision of medical facilities and location of physicians in areas not adequately supplied.

II. Medical care of the indigent and those having chronic illness.

III. Medical care of those of low income who are able to pay for ordinary medical services, but upon whom an unusual expense because of illness creates hardship or requires protracted payments.

IV. Medical care of those who are well able to care for themselves financially and do not desire any interference with their program of living. This group does not need attention other than that the medical profession must continue to maintain high standards of medical care for them as well as other groups.

Included within these groups are several million individuals who because of religious beliefs or other reasons do not consult physicians or desire medical care. So long as these people do not expose others to communicable disease, this freedom may not be abridged.

This subject could be still further subdivided, but for brief discussion this grouping directs attention to the major points to be considered.

I. Provision of Medical Facilities: The establishment of hospitals and laboratories and other medical facilities in areas not having adequate provision to meet medical needs meets with general approval. Grants of government aid to areas

*Presented at a Health Insurance Conference conducted by the Chamber of Commerce of the United States of America, in Washington, January 11, 1945.

where need is demonstrated has also been generally approved. The details of determination of needs, or of the management, local or national, of these facilities can not be discussed here. Nursing service and better community health protection may be the items of greater need. Education of the public in health matters, and in utilization of modern facilities in the treatment of illness, are necessary. It will not be difficult to get physicians to locate in areas where facilities and economic status make good medical care possible, but it must be pointed out that the needs of these inadequately-supplied areas can not properly be used as a reason for subjecting to national regulation the major portion of the country having more advanced standards and facilities. The areas of higher standards will progress better under their own planning than they would under any governmental pattern.

II. The Medical Care of the Indigent and Chronically Ill: Concerning this group it would seem that there could be no difference of opinion. They should be cared for at governmental expense from tax funds. Indigency results from many conditions, among them economic causes in which illness is only incidental, factors of habit, thriftlessness and subnormal mentality, as well as those whose indigency is primarily due to chronic illness. Cases of indigency of economic origin and those due to constitutional inadequacies, crippling or chronic disease cannot properly be loaded on insurance funds. These funds are accumulated from regular premium payments as a means of advance budgeting against the average incidence of illness as it may occur in those mentally competent and presumably well. To include the chronically ill would force unjustifiable burdens upon the shoulders of this group and also result in deterioration of medical services available to them. The economic casualties, accidents of birth, constitutional inadequacies, and cripples should be supported by the whole taxable group and not from the funds of a limited insured group.

Study of the manner in which governmental agencies have met the indigent need for medical care reveals what in many respects has been the most disappointing finding. In many cases the medical care of this group has been provided almost entirely by non-governmental agencies or charitably-inclined individuals and physicians who gave their services without charge. The urge to provide political sales talk by a record of low cost to the taxpayers apparently prompts many public officials to set up evasive formulae by which indigency is determined. The same formulae are used to avoid responsibility for medical care even when the law permits a broad construction with respect to care in illness. If all governmental agencies would meet the medical needs of the indigent, as they are in most instances directed by existing law or as could be provided by minor legislation, there would not be any problem of medical care for the indigent.

III. Medical care to those of lower income who are able to pay for medical services in the average illness, but upon whom an unusual expense of illness creates hardship or requires protracted payments: The American Medical Association began the study of the needs of this particular group years ago. The individual in this group may be described as generally appreciative of good service, and therefore selective in his choice of the physician in whom he has confidence. He is an individualist in his thinking and objects to interference with his own planning. Despite the absence of a large financial reserve he gets by very well. Although the unpredictable illness may require budget payment, he pays debts incurred within a reasonable time. In this the physician helps him, and surgical or other fees are generally adjusted to his ability to pay within a year. In fact, the illness, if not unusually expensive, may be much less burdensome than his payments upon the new automobile, refrigerator, radio, and household furniture that will be repossessed by the seller if he fails to make payments as promised. Credit authorities state that the aggregate obligations of the group for these purchases sometimes due to high pressure sales are very large in amount. As compared with these, the debts incurred for medical services are negligible.

To meet the particular problem of catastrophic illness and its effect upon this group, insurance plans in operation all over the world were studied by the American Medical Association to explore the possibilities of some mechanism by which budget payments into an insurance pool might provide funds for medical needs as they develop.

Government compulsory plans in other countries were studied as to advantages, disadvantages, tendencies to loss of the importance of the individuality of the patient, and to deterioration of quality of the service. Political manipulation and exploitation for political jobs and diversion of insurance funds to various purposes were reported.

Various constituent state medical associations also studied the possibilities of insurance plans as related to the medical problems of their respective states.

The American Medical Association approved and encouraged well-planned study and experimentation in the use of insurance plans whereby budgeted payments could be accumulated to be available for the payment of medical care at the lowest possible cost without impairing the quality of the service. Twenty states now have such plans in operation, or are in the process of preliminary study, enabling act or experimentation sponsored by the state medical society. In addition, thirty-eight states cooperate with the Farm Security Administration. Most of the plans of state societies are now on a sound financial basis. The service offered varies, but changes are brought about as actuarial information is gained. Some of the plans have been in existence a number of years. However, most of them are less than four years old. As a con-

sequence there has not been sufficient time for the public to become thoroughly familiar with this insurance method. Because of the lack of actuarial experience, many of the plans have not accepted more than one thousand new subscribers per month. Despite this short period of time, one of the plans has approximately a million members, and another one only slightly less than a million. Other state plans have been growing in number, and the total membership is now reported in excess of three million. This does not include hospital insurance. Also, it does not include any of the plans connected with industry in which it has been estimated that more than twenty million are covered by some kind of group insurance to protect against sickness costs.

The types of insurance vary, some plans being entirely service-type plans and others indemnity type. The service type in general have upper income limits upon those who can secure membership. The income limits in general, specified are not to exceed $2,400 per annum. The indemnity type are not limited to any special income group.

Any prepayment plans in which funds are pooled to meet future needs are in essence a type of insurance, and most states require substantial reserves deposited with the state insurance departments to guarantee the fulfillment of the contracts. Special legislation has been enacted in some states under which only a very minimum of reserve deposit is required from certain organizations. The guarantee that the service will be rendered by participating physicians is accepted in lieu of the larger reserves required of other types of insurance. Many physicians have participated in these service plans, in a desire to cooperate in the experimental study of the possibilities of this type of insurance, but who would not participate if the plan placed the major portion of their practice on that basis.

The indemnity type of insurance has the advantage of being more elastic, more universally applicable, and has been generally accepted by the profession in the many types of health insurance which have been operative throughout the years. It leaves the patient in control of the selection of his physician.

Some of the state plans in operation are limited to surgical and obstetrical service. Others provide both medical and surgical services to male and female and are closely integrated with existing hospital plans so that the purchaser of such insurance has coverage of all the phases of medical care.

These plans seem to be not only quite satisfactory but increasing in popularity despite the fact that in most instances there has been no active sales effort. In a number of states plans are being made to extend the protection to illnesses not now included.

Public opinion surveys in communities having these mutual types of insurance and in other communities not having insurance have indicated a high percentage of individuals who desire some kind of insurance protection. The same individuals, however, are reported to have voted strongly against government compulsory sickness insurance.

Some years ago conferences were held by representatives of the American Medical Association with representatives of organized labor with reference to medical care in industry and to the families of the employed, giving special thought to the possibility of some insurance plans. A vice president of one of the larger units of the American Federation of Labor spent some time in Europe, representing the Federation of Labor, in studying compulsory sickness insurance plans. On his return his recommendation was definitely against the operation of such compulsory plans. He reported many observations of the unsatisfactory character of the service and its administration under government control. Labor has repeatedly stated its objection to the contract doctor.

The Council on Industrial Health, of the American Medical Association, in conference with representatives of the American Federation of Labor, the Congress of Industrial Organizations, the National Association of Manufacturers, Stock and Mutual Insurance companies, the Public Health Service, and other agencies have come to agreement upon far-reaching plans for Health in Industry. These plans provide for health education including nutrition, prevention of illness, physical examination, confidential records, and selective placement in suitable jobs; confidential consultations between the industrial surgeon and the private physician of the patient in matters relating to the health of the employee, and simplified processes of adjustment in compensable illnesses and injuries were approved.

Many of the employees are now covered by hospital insurance to which premiums the employer and employee contribute. In a number of industries these health measures, as outlined, have been so satisfactory to both parties that the possibilities of extending the coverage to the families of employes is being discussed. The attitude of labor toward governmental compulsory insurance plans at this time has been variously stated by some representatives of labor organizations. Where individuals and groups of members of labor organizations understand the implications of compulsory government sickness insurance the attitude has not been in favor of compulsory government insurance.

The American Medical Association has for many years given study to the costs of good medical care with a view to keeping that care available to the low-income group without deterioration of quality. Better organization and higher standards in specialization with proper facilities for good work at a minimum charge have been encouraged. Group participation in the use of office facilities, also the grouping of medical men in the various specialties of medicine in the joint ownership of facilities,

commonly referred to as group medicine, are being tried.

At the close of World War I, there was heightened interest in group medicine and many organizations were established in various parts of the country. Not all of these group organizations continued as operating units over any great period of time. Some of the physicians continued to occupy adjoining offices, although they practiced as individuals not professionally associated. It would not be helpful to discuss the varied reasons for these failures, but it must be remembered that the individual patient is still an individual. He will place his confidence in Dr. Jones and will have nothing to do with Drs. Smith and Brown. No one can deny him the right of the choice of his confidential adviser.

The effect upon the cost to the patient in group practice is apparently not impressive. Some costs may be moderately reduced in various group organizations, but it must always be borne in mind that the practice of medicine is an individual service, and that the physician can give the best medical service to only a comparable number of patients regardless of the type of organization in which he is working.

Medical science has made remarkable progress. The average of human life has been greatly extended, and the quality of life in terms of physical and mental health and happiness has been made better in similar proportion. A recent report by an insurance company, based upon a study of causes of death, estimated that more than one million lives have been saved in the past year as compared with the average annual mortality over a long period, due to progress in the medical treatment of certain diseases. However, the very progress that has made possible this remarkable prolongation of life and better levels of health has made medical service more costly with reference to the facilities required—hospitals, special equipment, special laboratory tests, and trained-nurse care in addition to the closest observation and care by physicians. Today good medical care cannot be cheap.

Every possible plan of improvement of the methods of distribution of medical care is constantly being studied.

## CONCLUSIONS

I. Government aid should be extended in the provision of medical facilities in areas where need is determined.

In the determination of that need the local community should have a voice, and should have the control and operation of facilities thus provided.

II. The indigent should not be included in any plan of insurance, even though payments be made by the government, because of the abnormal concentration in that group of the congenital defectives, crippled, and chronically ill. Those who have insufficient income to live properly under healthful conditions would also fall in the same high liability group. Both would become unfair burdens upon the pooled funds contributed for insurance purposes by those living under average conditions with normal nutrition, reasonably healthful conditions of employment, and normal housing.

The economic needs of this group should be met from general tax funds. The American Medical Association is now giving thought to the problem of the chronically ill. Many of these patients should have treatment not available in the home. Many require nursing care that is beyond the physical capacity of the family to provide. Probably some new kind of institution will be necessary to meet this need. The long duration of chronic illness makes it impossible to take care of these patients in hospitals whose facilities are necessarily geared to the needs of acute cases.

A better approach to the problems of the indigent can, no doubt, be worked out through cooperation of the responsible public officials with the medical profession.

The statement frequently repeated that one-third of the public are unable to have needed medical care because of insufficient income is a broad generalization based upon economic variables that change constantly. Certainly it is not true now, and there are so many undefined and changing factors that it could not be proved at any time. It is noteworthy that in the group of those of reported low income were millions of small farmers who obtain almost all of their living needs from their farms. Among them, in areas studied, indigency was almost unknown and health and comfort levels were high despite the small income in money. At any rate, such economic disability as actually exists in the group should be adjusted from an economic basis and not be placed as a burden upon the shoulders of others under some misleading type of insurance. Incidence of illness is influenced greatly by economic status, nutrition, clothing, housing, and conditions of employment. Economic causes of illness require economic treatment and are not corrected by medical treatment of illnesses that will recur as a result of continuing economic causes.

III. Those of lower income who are able to pay for ordinary medical service but find any serious illness difficult to finance: This group is normally employed, their living conditions approach that of the average, and their contributions to an insurance pool is for the purpose of meeting extraordinary costs due to prolonged illness and disability. The contributions of this group to insurance funds and the hazards of illness among members of the group which will result in demands on those funds are substantially equal. To them insurance offers a useful mechanism for providing for budgeted payments in advance of needs, and the equitable distribution of the entire cost. This is the group who have expressed the greatest interest in sickness insurance. Many of them would prob-

ably purchase such insurance at once if they were contacted by a dependable insurance company. This group has in substantial majority expressed opposition to any compulsory government insurance plan.

IV. This group is made up of those to whom the ordinary incidence of illness does not constitute a hazard of extreme hardship. Those who wish to avail themselves of insurance protection find it possible to do so with private companies, and are obviously not in need of government help.

The American Medical Association has approved of the use of insurance to protect against the hazards of illness, but has consistently opposed the establishment of compulsory government insurance. The reason for this opposition can be briefly stated. The profession is interested in maintaining the highest quality of medical service, and it has opposed any proposals that would lead to deterioration of service. Government-controlled medical service is dependent upon regimentation of the public and the medical profession. The bureaucratic administration which develops as a part of governmental control must inevitably lead to standardization of service at a minimal level. Standardization is never at the level of superior work, but must always be made low enough to include that of lesser quality. The minimal standard thus tends to become the average level.

Those who advise government compulsory insurance plans repeatedly use for public appeal the "need for medical care by those who cannot pay for it." As pointed out, the indigent group cannot in fairness to others be included in any insurance plans. However, the proposed government compulsory plans for prepayment by insurance methods do not permit the individual to use the insurance funds to which he is entitled, to purchase needed medical care. To the contrary, government possession of the insurance funds is apparently to be used as a means to secure government control of all the conditions under which the medical service could be provided.

It is an idle statement to say that under such plans the individual could still have his own choice of physician when the conditions of bureaucratic medicine would not be acceptable to a portion of the best physicians, and therefore they would not be available to the patient.

The statement that personal interest and confidential relationship between physician and patient is not important betrays a lamentable lack of understanding of emotional factors and of psychosomatic manifestations of illness, and consequently the essential helpfulness of the confidential personal adviser—his physician.

It is not realistic to say that medicine would continue to attract the best minds if the possibilities for advancement in the profession would have to await the "nod" of some political bureaucrat, or if opportunity and incentive were stifled in the mechanics of a governmental structure.

It is a distortion of facts to point to the remarkable work of the medical profession of the Army and Navy in war as an evidence that a regimented method for medicine is superior or more desirable. It must be recognized that all but a very few of the medical officers of the armed forces are civilian doctors nearing middle life who are applying their skills acquired in civilian training and experience to the treatment of the unusual exposures and physical and mental wounds of war.

At the conclusion of the war these physicians and patients will return in full agreement that although regimentation is necessary in the Army, it is undesirable in civilian life. As a more American, wholesome, self-reliant method of securing protection against the costs of unusual or serious illness for those to whom that protection is desirable, the American Medical Association and its constituent associations are endeavoring to be helpful in securing protection through familiar insurance mechanisms. Medical associations have no desire to enter into the insurance business, and private insurance companies are finding this a desirable field of new business. If private companies are not interested at costs within the capacity of the individuals to pay, mutual and cooperative efforts will no doubt increase. Other methods may be found.

Benjamin Rush, an eminent American physician, signer of the Declaration of Independence, said in 1790 that when political independence had been gained and a new form of government had been established upon a basis of principles new to any government, there still remained to be developed along those lines an American economy free from European domination; an American jurisprudence; an American system of medicine; an American orthography; an American plan of education, and an American literature.

An American system of medicine of a higher standard than is enjoyed anywhere else in the world has been developed and continues to progress. The American Medical Association for nearly a hundred years has directed its efforts to the improvement of medical service and the broadest distribution of its benefits to the public.

It now becomes necessary to protect the public by opposing the substitution of an un-American system of medicine with bureaucratic regimentation of patients and physicians, such as would destroy those American qualities of medical service that are most important to health and the American way of life.

The American Medical Association will direct its efforts to still further advancement of medical science, and will continue to explore every means of making the best possible medical service available to all the people.

# ON PROVIDING FOR DISTRIBUTION OF PROPERTY WITHOUT A WILL

ALBERT STUMP

INDIANAPOLIS

While as a general rule persons who have property should make wills unless they are certain that the distribution of their estate under the law will be satisfactory, yet there are situations in which a will is not the solution to the problem.

Under the law, the interests of the widow or widower are carefully guarded. A man cannot disinherit his wife by means of a will, nor can a wife disinherit her husband by means of a will. Each has the right to elect or choose whether to take under the law or under the will of the deceased spouse. The statute in that regard, as it pertains to the wife, reads as follows:

"*Burns*, 1933, Section 6-2332. (3356). Wife—Devise—Election. Whenever any personal or real property be bequeathed to any wife, or a pecuniary or other provision be made for her in the will of her late husband, such wife shall take under such will of her late husband, and she shall receive nothing from her husband's estate by reason of any law of descent of the state of Indiana, unless otherwise expressly provided in said will, unless she shall make her election to retain the rights in her husband's estate given to her under the laws of the state of Indiana, which election shall be made in the manner hereinafter provided (Acts 1907, Ch. 48, Sec. 1, p. 73)."

The statute pertaining to the husband's rights reads exactly the same except that the words "husband" and "wife" change places.

The election is made by filing "his or her election in writing, duly signed and acknowledged before some officer authorized to make acknowledgement of deeds, and such election shall be made and filed within one year after such will has been admitted to probate."

Supposing that a man marries a woman who has children by a former marriage; that it is his first marriage; and that there are no children born of this marriage. Supposing the wife has a substantial estate, and desires to protect that estate for the benefit of her children. If she did nothing but make a will the husband could take under the law and would receive one-third of her personal property and a life interest in one-third of her real estate. In that situation, if the husband and wife desire to avoid such a result they require an ante- or a post-nuptial agreement regarding the wife's property.

Supposing that a man and woman marry and they have no children, but that the man furnishes a home for his brother's children, and desires to aid them through his will, that purpose could be entirely frustrated, for if the husband had neither father nor mother nor descendants living at the time of his death, and the wife survived him, she could choose to take under the law and would receive his entire estate. If this situation could not be solved by gifts during the lifetime of the husband and wife, for instance because of the wife refusing to join in deeds to real estate, then the problem could still be solved by the husband adopting the children of his brother. The wife would then receive one-third of his estate and the children two-thirds by the operation of the laws of descent.

What has been said up to this point is sufficient to illustrate the necessity for consulting with attorneys who are informed in these matters, or will take the time and put in the effort necessary to look up the law applicable to the situation, and then advise in accordance with the law.

As a matter of observation and experience, as it is recorded in the law books, there seems to be less difficulty in making arrangements during the lifetime of the interested parties regarding the distribution of their estate than in obtaining concessions and adjustments after the death of one of the parties. The presence of an estate with the immediate prospect of possession subjects the generous impulses of many people to too great a strain. But these same people, in order to appear generous and to avoid difficulties and live tranquilly together, often are not so reluctant to agree on these matters when they canvass and consider them together.

So the making of a will, or the making of any other arrangements regarding the settlement of one's estate, should be done between the living in their prime of life, if that is possible, and not when age and disappointment may have warped their judgment regarding those who were nearest to them in their better days. But this suggestion should not be carried to the point where the person in old age disregards obligations incurred because of solicitude and service given in his behalf which should be decently rewarded.

Of course, where unmarried people without children, or others who would naturally have a just claim upon their estate, come to the making of their wills, or the distribution of their property otherwise, there are no limitations upon what they may do to achieve their desires so long as their desires spring from a sound mind, and the objectives and the means of accomplishing them are lawful.

Unsoundness of mind renders any transaction voidable, unless the person of unsound mind is under guardianship. If the person is under guardianship, then his act is void. The distinction between a voidable act and a void act is that the voidable act may be affirmed and be binding after such affirmance. The affirmance may be by the person after he has been restored to sanity, or it may be by his guardian. It is voidable only at the option of the insane person. That is, the insane

person or his representative may rescind, or set aside, or cancel the thing that had been done by him, and may be excused from performance of his contract. This is not done without regard to the equities of the situation, for where a voidable act is involved the courts will attempt to restore the parties to the status existing before the act. But where an act is void, then it is the same as if the act had never been done. It can never be affirmed. It has no legal force and effect. It is only a legal nullity.

Further discussion of unsoundness of mind as it may affect the protection and disposition of an estate will appear in a later article.

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## INDIANA UNIVERSITY SCHOOL OF MEDICINE REQUESTS RELEASE OF FACULTY MEMBERS FROM ARMED FORCES

**A letter sent to the editor by Dean W. D. Gatch, of the Indiana University School of Medicine, showing the need for release of its teachers merits due consideration, and is accordingly published in the THE JOURNAL. The medical center has carried on a full-fledged schedule during the emergency, in spite of its curtailed faculty, and deserves much credit. It now feels that the time is approaching when its key men should be returned to their posts.**

"August 7, 1945.

"Dr. E. M. Shanklin, Editor,
THE JOURNAL, Indiana State Medical Association,
Hammond, Indiana:

"Dear Dr. Shanklin:

"I write you concerning the release of teachers of the Indiana University School of Medicine from the armed forces. The medical school has at present eighty-one members of its faculty—almost every man under fifty—in the Army and Navy. It has now been on the accelerated program for almost four years. The faculty at home has been overworked to keep the school going.

"I have sent three earnest requests to the Surgeon General for the release of essential teachers. The first request was returned with the statement that it asked for the release of too many men. No action has been taken on the other requests. We can not do anything more than we are doing at present until this request is granted. We face a tremendous problem in giving postgraduate instruction to physicians returning from the war. We need men to carry out worthwhile research projects. We need to start a school for physical therapists. We need to train more men in roentgenology and pathology. These are only a few of the things the school will be expected to do, and must do, but we can do none of them until a sufficient number of our faculty members come back to us.

"The faculty members who have kept the medical center going for the last four years at a great sacrifice of time and labor deserve great praise. It would be a shame to have the school criticized for not doing what it needs to do and is expected to do because, through no fault of its own, it does not obtain the necessary teaching force. So far we have found the difficulties of securing the return of our teachers insurmountable.

"Indiana physicians went all-out for the war, and the faculty of the Indiana University School of Medicine did likewise. I doubt if any medical school sacrificed more. I believe that a large number of these men ought now be returned to us. They have done their full duty toward their country, and the school can no longer get along without them.

Sincerely yours,

W. D. GATCH, M.D.,
*Dean, Indiana University School of Medicine.*"

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"Forever float that standard sheet!
Where breathes the foe but falls before us,
With Freedom's soil beneath our feet,
And Freedom's banner streaming o'er us."

# REQUEST BY CHAMBER OF COMMERCE FOR RELEASE OF PHYSICIANS FROM THE MILITARY

Because of the need for physicians for civilian practice, and in the hope of expediting the release of physicians from the armed forces, Mr. William H. Book, Executive Vice President of the Indianapolis Chamber of Commerce, recently sent a letter to the Honorable Louis Ludlow, Representative of the Eleventh District, and the Indiana delegation—two senators and eleven representatives— urging that the Army and Navy departments review their policy concerning the retention of physicians, making such changes as factual study would indicate. Since this concerns our members in the military and is in keeping with the appeal recently made by the Executive Committee of the Indiana State Medical Association for the release of medical officers, we are quoting Mr. Book's letter, together with the replies he received from Representative Ludlow and Major General George F. Lull, Deputy Surgeon General of the United States Army:

**INDIANAPOLIS CHAMBER OF COMMERCE**
**Indianapolis**

"July19, 1945.

"Honorable Louis Ludlow,
House Office Building,
Washington, D. C.
Dear Mr. Ludlow:

"I believe that some representations already have been made to you concerning the lack of use of physicians in the armed forces and urgent need for release of those not needed because of the shortage of physicians in civilian practice. The Indiana State Medical Association has formally urged the Army and Navy departments to review their policy and practice on retention of physicians.

"We should like to add our voice to that of the medical association. From the personal observation of many Indianapolis businessmen, the physicians in our community, as no doubt elsewhere, are greatly overworked. I have heard such testimony as this: 'I am turning away as many people every day as I can take.' 'Seven doctors here have died in the past month, largely from over-work.' 'The older doctors who should have retired because of their own physical condition are carrying heavier loads than they ever should have carried even in their prime.' 'I was at a doctor's office at the close of his day's work, and was even then nineteenth in line.' 'I called at a doctor's office at 7:30 P.M. for a prescription, and it was 11:15 P.M. before he could get to me.'

"These are samples of what we are hearing with great frequency from all types of persons. At the same time, we are hearing charges that the armed forces are retaining physicians who are not needed and who consequently have very little or no work to do. It goes without question that no citizen wants to see the armed forces stinted in any way. We fully agree with the desirability of having more than enough, rather than too little of anything, including medical service. However, we are of the opinion there is real basis for the contention that the armed forces are retaining doctors far beyond their real or possible needs, and to the great detriment of the civilian population, as well as to the doctors themselves, both those in the armed services and those who are in civilian practice.

"I am writing, therefore, to suggest that you might be most helpful by presenting the problem to both the Army and Navy departments, with the purpose of having them review their policy and make such changes as a factual study would indicate. I am sure your action on this would be much appreciated by a great many Indianapolis citizens.

Very sincerely yours,

WILLIAM H. BOOK,
*Executive Vice President,*
*Indianapolis Chamber*
*of Commerce.*"

* * * *

**COMMITTEE ON APPROPRIATIONS**
**House of Representatives**
**Washington, D. C.**

"July 25, 1945.

"Mr. William H. Book,
Executive Vice President,
Indianapolis Chamber of Commerce,
Indianapolis, Indiana.
Dear William:

"Replying to your letter in regard to release of doctors from the military service, I will say that this matter has been very much on my mind because of the reasons so well stated in your letter.

"I took up the matter aggressively with the Office of Surgeon General to see if releases of doctors cannot be expedited because of the distress in civilian communities as a result of a lack of medical services.

"I cannot explain the official attitude more completely, I believe, than by sending to you a copy of a letter received a few days ago from Major General Lull, the Deputy Surgeon General. You will find it enclosed. You will note his advice that requests for release of Indiana doctors be supported in each instance by a statement from Dr. Bird, of Indianapolis, the state chairman of the Procurement and Assignment Service for Indiana.

"I wish I could do more to assist in this matter. Have you further suggestions? If agreeable to you, I would like to transmit your letter to General Lull.

Very sincerely,

LOUIS LUDLOW."

**WAR DEPARTMENT**
**Army Service Forces**
**Office of the Surgeon General**
**Washington, D. C.**

"14 July 1945.

"Honorable Louis Ludlow,
House of Representatives,
Washington, D. C.

Dear Mr. Ludlow:

"This is to acknowledge your letter of 12 July 1945, with inclosures, which are returned herewith, concerning the release of doctors from the military service.

"I wish to inform you that with the announcement of the War Department's over-all policy to release officers, the selection of such officers will be determined by their adjusted service rating scores, the desire of each officer as to his retention in the service, efficiency, and military necessity. It will be necessary for individual officers to be compared with other Medical Corps officers who have been in the military service since 16 September 1940, in order to determine their essentiality to the Army in the continuation of hostilities with Japan. This method of determination will allow an equitable relief from active duty of officers on the basis of their age, length, and type of service, in addition to dependents.

"Should an individual officer desire to be considered for relief from active duty on any other basis than by his adjusted service rating score, it is necessary for him to initiate his own request through channels under the appropriate provision of *War Department Circular 485*, dated 29 December 1944. His request should, of course, be supported by a statement from Dr. Charles R. Bird, 23 East Ohio Street, Indianapolis, Indiana, state chairman of the Procurement and Assignment Service for Indiana, showing his need to the civilian community.

"I wish to assure you that careful consideration will be given to officers' requests for relief from active duty, for the national health safety and interest, when they are received in this office, consistent with the needs of the military service.

Sincerely yours,

George F. Lull,
Major General, U.S.A.,
Deputy Surgeon General."

---

# RED CROSS HOME NURSING COURSE: ITS ADVANTAGES TO THE PRACTICING PHYSICIAN

CAROLINE HELMICK, M.D.

NORTHFIELD, MINNESOTA

The American Red Cross Home Nursing course was expanded in recognition of the present critical health needs in our country. The overcrowding of hospitals makes home care of minor illnesses a necessity, and with the shortage of nursing personnel, professional nursing care is often not to be had. The bedside care of the person who is ill at home then becomes the responsibility of some member of the family.

The course is designed to provide instruction and supervised practice in carrying out simple nursing procedures, such as taking a temperature with a clinical thermometer, keeping the patient comfortable in bed, giving a bed bath, giving medications and simple treatments prescribed by the physician, serving a tray, including proper selection of foods for the invalid, improvising sick-room equipment from materials which are readily at hand, such as pasteboard cartons for backrests and bed tables, and newspapers for waste disposal, and other nursing skills and techniques. It also includes instruction in the recognition of illness and the prevention of the spread of communicable disease.

The advantages to the physician of having someone with this training in the home where his patient must be cared for without the services of a graduate nurse are obvious. He has some assurance that the person caring for the patient has some knowledge of how to keep the patient clean and comfortable, and how to give ordinary bedside care with a certain amount of proficiency. The physcian is spared the necessity of giving detailed instructions for certain treatments, such as hot and cold applications, steam inhalation, et cetera. Nor does he have to explain the need for and techniques of simple procedures, such as handwashing and disposal of waste to prevent the spread of communicable disease.

The attitude of the individual who has had even a minimum of training in nursing techniques has become more objective and less emotional. She approaches her tasks with greater confidence in her own ability, and this in turn is reassuring to the patient.

Local Red Cross chapters everywhere are at present accepting applications for fall classes. You can add to your own peace of mind by urging that at least one member of every family in your community enroll in a Red Cross Home Nursing Course.

# Indiana Martyrs in World War II

*"THESE heroes are dead. They died for liberty—they died for us. They are at rest. They sleep in the land they made free, under the flag they rendered stainless, under the solemn pines, the sad hemlocks, the tearful willows, the embracing vines. They sleep beneath the shadows of the clouds, careless alike of sunshine or storm, each in the windowless palace of rest . . . they are at peace. In the midst of battles, in the roar of conflict, they found the serenity of death."*

—*Vision of War,* by Robert Green Ingersoll.
(Speech at Indianapolis, Indiana, September 21, 1876.)

Lieutenant John Francis Kerr, Jr., M.C., of Indianapolis, died August 18, 1942, at El Paso, Texas, from injuries suffered in an accident.

Lieutenant Emil Nicholas Kveton, M.C., U.S.N.R., of Fort Wayne, killed in action at sea on August 9, 1942.

Captain Robert Carl Badertscher, M.C., A.U.S., of Bloomington, died in an Army bomber crash at Iquito, Peru, South America, early in September of 1943.

Lieutenant Kurt Benjamin Klee, M.C., A.U.S., of Indianapolis, killed in action the first day of the Allied invasion of Sicily, July 10, 1943.

Captain Harry D. Miller, M.C., A.U.S., of Shelbyville, killed in an accident while serving with the United States Medical Corps in Algeria, February 2, 1944.

Colonel Frank Bolles Wakeman, M.C., A.U.S., of Valparaiso, died March 17, 1944, while attending an officers' conference at Fort Monmouth, New Jersey.

Captain John Elliott Carter, M.C., A.U.S., of Richmond, killed in action in the Southwest Pacific, July 22, 1943.

Lieutenant Commander Martlin P. Smith, M.C., of Muncie, killed in an automobile accident in North Africa, July 5, 1944.

Major Michael A. Rafferty, M.C., A.U.S., of Elkhart, killed in action in Belgium, November 24, 1944.

Captain Robert B. Miller, M.C., A.U.S., died on April 30, 1945, at the Percy Jones General and Convalescent Hospital, Battle Creek, Michigan, from injuries received in Germany.

Lieutenant William Vincent Eckhart, M.C., A.U.S., of Marion, killed in an automobile accident, May 17, 1945.

Captain Charles Dougherty Clark, M.C., A.U.S., of South Bend, killed April 28, 1945, as the result of a Japanese suicide plane attack, which crashed into the *U.S.S. Comfort*, naval hospital ship, fifty miles off Okinawa.

# Deaths

**Julian E. Hanna, M.D.,** of Noblesville, died recently following a long illness. He was seventy-four years of age. Doctor Hanna was a graduate of the Medical College of Indiana, in Indianapolis, in 1905.

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**John L. Dunkel, M.D.,** of Freemont, died in a hospital at Battle Creek, Michigan, on July tenth. A graduate of the Medical College of Ohio, in Cincinnati, in 1896, Doctor Dunkel had practiced in Fremont for forty-nine years. He was eighty years of age.

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**James Michael Dinnen, M.D.,** of Fort Wayne, died recently after a month's illness. He was eighty-nine years of age. Doctor Dinnen was the oldest living graduate of Rush Medical College, having graduated in 1879.

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**Frank C. Tinsley, M.D.,** of Indianapolis, died on August twenty-third at the age of eighty-one. He was a graduate of the Central College of Physicians and Surgeons, in Indianapolis, in 1891, and had practiced medicine in Indianapolis for more than fifty years.

---

**Guy W. Seaton, M.D.,** of Indianapolis, died at a local hospital on August twelfth, after an illness of several weeks. He was seventy-two years of age. Doctor Seaton was a graduate of the Medical College of Indiana, in Indianapolis, in 1898, and had practiced in Indianapolis for thirty years. He limited his practice to otorhinolaryngology, and was certified by the American Board of Otolaryngology. He took some postgraduate work at the Vienna Clinic in Austria. He was a member of the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and the American Medical Association.

---

**A. G. Miller, M.D.,** of Hobart, died suddenly on August second. He was fifty-two years of age. Doctor Miller was a graduate of Loyola University School of Medicine, in Chicago, in 1922, and had taken two postgraduate courses in Vienna. He had practiced medicine and surgery in Hobart for twenty-two years, and had served as deputy Lake County coroner and Hobart Health Commissioner. Doctor Miller served in France with the United States Army Medical Corps in World War I. He was a member of the Lake County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

**Clarke Enoch Stewart, M.D.,** of Vincennes, died recently at the age of seventy. He was a graduate of the Kentucky School of Medicine, at Louisville, in 1897.

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**Charles J. Hufnagel, M.D.,** of Richmond, died at the age of fifty-five, on July twenty-second. After graduating from the University of Louisville School of Medicine, in 1914, Doctor Hufnagel practiced surgery in Richmond. He was a veteran of World War I. Doctor Hufnagel was a member of the Wayne-Union County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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**Howard Alva Garner, M.D.,** of Hanna, died suddenly on July eighteenth while en route to Chicago. Doctor Garner was fifty-six years of age. He graduated from the Indiana University School of Medicine with the class of 1920, and had practiced in Hanna since that time. Doctor Garner had been an examining physician for a local draft board in La Crosse since 1940, and was deputy coroner of LaPorte County. He was a past president of the LaPorte County Medical Society, and was a member at the time of his death. He was also a member of the Indiana State Medical Association and the American Medical Association.

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**Edward M. Amos, M.D.,** of Indianapolis, died July nineteenth at the age of seventy-nine. Doctor Amos was a graduate of the Central College of Physicians and Surgeons in 1891, and had practiced in Indianapolis since 1898. Doctor Amos was a pioneer in tuberculosis control work in Indiana, and it is stated that as president and member of the Indiana Tuberculosis Association he was largely responsible for the holding of the early tuberculosis clinics throughout the state. He was an honorary member of the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and the American Medical Association.

---

**James W. Baxter, Sr., M.D.,** died recently at his home following an illness of two months. He was a graduate of the Kentucky School of Medicine, in Louisville, in 1903, and had practiced medicine in New Albany for thirty-six years. He was a veteran of World War I. Doctor Baxter was a member, and a former president, of the Floyd County Medical Society. He was also a member of the Indiana State Medical Association, and a Fellow of the American Medical Association.

# Annual Report Number

of

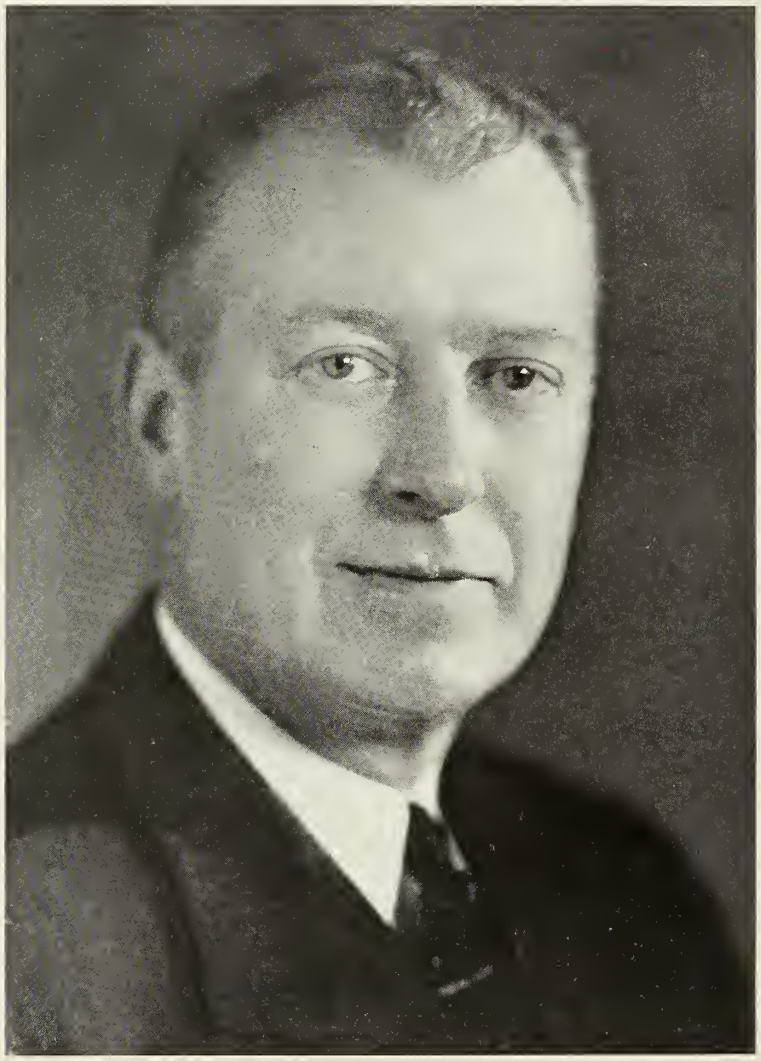
# THE JOURNAL

of the

# INDIANA STATE MEDICAL ASSOCIATION

## Indianapolis, Indiana

Reports of Officers
and Committees



**N. K. FORSTER, M.D.**

HAMMOND

President

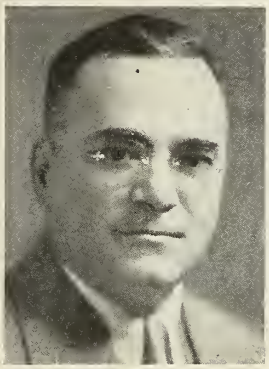
Indiana State Medical Association

1945

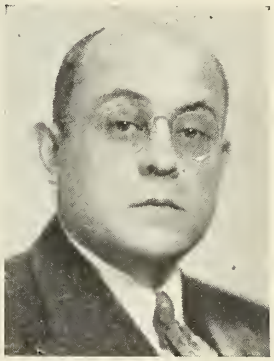
# INDIANA STATE MEDICAL ASSOCIATION

## Officers - 1945

J. E. FERRELL
President-Elect
Fortville



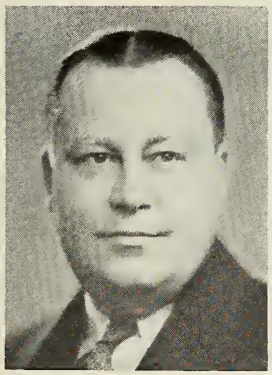
F. T. ROMBERGER
Chairman of Council
Lafayette



A. F. WEYERBACHER
Treasurer
Indianapolis

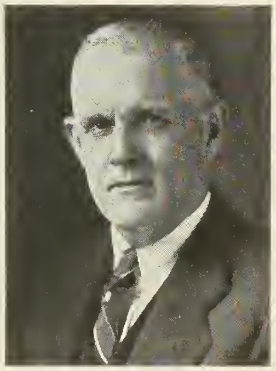
THOMAS A. HENDRICKS
Executive Secretary and
Managing Editor of
THE JOURNAL
Indianapolis

CLEON A. NAFE
Chairman
Executive Committee
Indianapolis

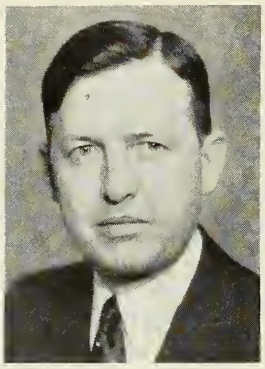


RAY E. SMITH
Assistant Executive Secretary
Indianapolis

E. M. SHANKLIN
Editor, THE JOURNAL
Hammond



C. H. McCASKEY
Executive Committee
Indianapolis

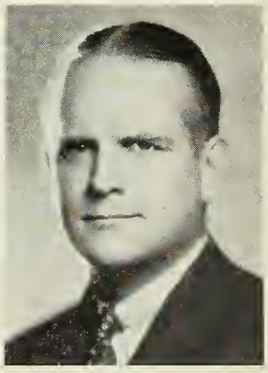


GEORGE A. COLLETT
Chairman
Section on Surgery
Crawfordsville

WEMPLE DODDS
Chairman
Section on Medicine
Crawfordsville

J. V. CASSADY
Chairman
Section on Ophthalmology
and Otolaryngology
South Bend

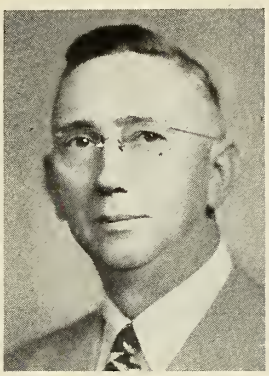
RUSSELL W. KRETSCH
Chairman
Section on Anesthesia
Hammond



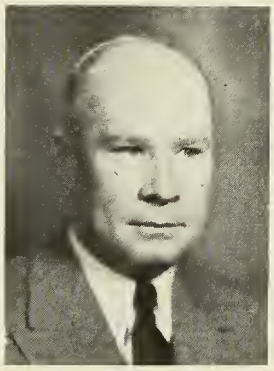
WILLIAM N. WISHARD
Secretary
Section on Surgery
Indianapolis

H. C. WURSTER
Secretary
Section on Ophthalmology
and Otolaryngology
Mishawaka

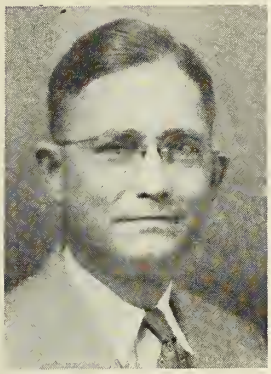
WILLIAM M. DUGAN
Secretary
Section on Medicine
Indianapolis



JOHN M. WHITEHEAD
Secretary
Section on Anesthesia
Indianapolis

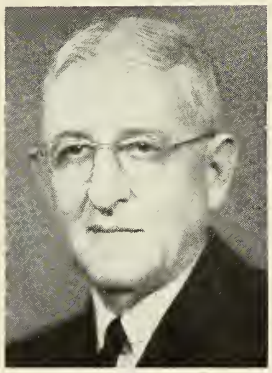


ERNEST RUPEL
Editorial Board
Indianapolis

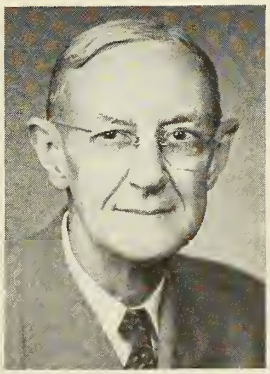


HARRY W. GARTON
Editorial Board
Fort Wayne

MINOR MILLER
Editorial Board
Evansville



MAYNARD A. AUSTIN
Editorial Board
Anderson



CHARLES N. COMBS
Editorial Board
Terre Haute

BERT E. ELLIS
Editorial Board
Indianapolis

## ANNUAL MEETING OF INDIANA STATE MEDICAL ASSOCIATION

The 1945 annual session of the Indiana State Medical Association, which was scheduled for the French Lick Springs Hotel, French Lick Springs, Indiana, October 2, 3, and 4, probably will have to be postponed.

An application is pending with the government authorities for the right to hold the 1945 annual session as scheduled. If granted, it probably will be for a date later on in the year, perhaps in November or December.

The regular annual meeting of the House of Delegates will be held sometime in the future, at Indianapolis, upon the call of the president, if permission to hold the annual meeting is not granted.

A one-day special meeting of the House of Delegates for the consideration of the report of the Committee on Prepayment of Medical and Surgical Care probably will be called within the next sixty days.

EXECUTIVE COMMITTEE

C. A. NAFE, M.D., *Chairman*,
C. H. McCASKEY, M.D.,
N. K. FORSTER, M.D.,
J. E. FERRELL, M.D.,
F. T. ROMBERGER, M.D.,
THOMAS A. HENDRICKS,
*Executive Secretary*.

## KEEP INFORMED!

Victory is here. So are many problems of peace, as can be seen in the annual reports of the officers and committees of the Indiana State Medical Association, published in this issue of THE JOURNAL. Each member is urged to read and study these reports, which cover important subjects such as medical care insurance, rehabilitation, new public health program, Wagner-Murray-Dingell Bill, postwar extension of the EMIC program, and the return of medical officers.

Read these reports—keep informed—so that you may do your part in solving the problems of peace as you have the problems of war.

# Reports of Officers and Committees

## EXECUTIVE SECRETARY

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

Now that the Emperor of Japan has made up his imperial mind to give up rather than be blown up, and the war is finally over, emphasis turns to our own American and Hoosier domestic affairs. Therein lie many problems, but as complicated and numerous as these may be the Indiana State Medical Association is ready to take a position of leadership in those matters having to do with health and medicine in this state. Many of the questions and some of the answers are discussed in the detailed reports of the officers and committees of the state medical association that appear in the following pages.

These reports have been prepared so that each member of the Indiana State Medical Association may be better informed in regard to some of the many social, economic, and scientific changes affecting medicine, which have occurred in the years from the bombing of Pearl Harbor until the atomic bombs hit Japan, which momentous event was taking place about the time most of these statements were written. Each of these reports come as the result of much study and discussion, and represents the best thought on the respective subjects covered by those who have been designated to make investigation into these various fields. These reports are to be considered by the members of the House of Delegates when they are called together, which probably will be just as soon as travel restrictions now in force to facilitate troop movements and the transportation of wounded and disabled servicemen are lifted.

Although prepared especially for the House of Delegates, it is hoped that each member of the Indiana State Medical Association, whether he is in the armed services or in civilian practice, will read these statements and translate his desires and wishes to his delegates. Many county medical societies already have held meetings and taken formal action, instructing their delegates in regard to matters of policy on various subjects.

Discussion, analysis, and final action on many important matters, such as health insurance, rehabilitation, return of medical officers from service, new state public health legislation, Wagner-Murray-Dingell Bill, and the proposed extension of the EMIC program will rest with the House of Delegates. Thus the members of the House of Delegates will be responsible for action which will affect the individual lives and welfare of the citizens and physicians of Indiana for years to come. The wisdom of their decisions will rest largely upon the extent to which each individual doctor of Indiana is informed.

In closing, I wish to express my personal thanks and appreciation to the officers and members of the Indiana State Medical Association in making it possible for me to serve on a part-time basis with the new American Medical Association Council on Medical Service and Public Relations. That Council has a job to do—a big job—which can and *must* be done for American Medicine and for the American public.

THOMAS A. HENDRICKS,
*Executive Secretary.*

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## TREASURER

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

The accompanying report prepared by certified public accountants gives our financial statement for the period ending December 31, 1944.

During the past year no additional bonds have been acquired and our financial statement as to permanent holdings remains unchanged.

The special assessment authorized by the House of Delegates in October, 1944, did not become effective until January 1, 1945.

The following is a statement of the George S. Olive and Company:

"January 16, 1945.

"The Council,
Indiana State Medical Association,
Indianapolis, Indiana.

Gentlemen:

"We have examined the cash records of your Association for the year ended December 31, 1944. This examination was undertaken for the purpose of determining and verifying the cash transactions for the year, and of verifying the assets and liabilities at the close of the year, as recorded on the records.

"The results of our examination are presented in this report, which includes: (1) text of comments; (2) statement of assets of all funds at December 31, 1944; and (3) statements of receipts and disbursements of all funds, year ended December 31, 1944.

### GENERAL COMMENT

"In Exhibit A is presented an analysis of the decrease in assets of the Association for the year ended December 31, 1944, showing in summary form the sources from which this decrease was derived.

"The decrease of $8,053.90 is attributable to: (1) an excess of operating cash disbursements over

operating cash receipts of the General Fund in the amount of $6,665.90; (2) an excess of operating disbursements over operating receipts of THE JOURNAL of the Indiana State Medical Association in the amount of $1,491.50; offset by (3) an increase in assets of the Medical Defense Fund of $103.50.

"During the period under review, funds were transferred from the Medical Defense Fund in the amount of $5,000. THE JOURNAL of The Indiana State Medical Association received $3,000, as may be noted in Exhibit D, and the Association received $2,000, as is set forth in Exhibit C. These amounts so transferred are to be considered as loans.

"Details of the assets of all funds are presented in Exhibit B. There were no recorded liabilities at December 31, 1944, and the assets shown represent the surplus of each fund at that date. We have examined the securities of the Association, and confirmed bank balances by direct correspondence with the depositories.

"Details of the cash receipts and disbursements of the General Fund, of THE JOURNAL of The Indiana State Medical Association, and of the Medical Defense Fund are presented in Exhibits C, D, and E.

Yours very truly,

GEO. S. OLIVE & CO.
*Certified Public Accountants.*"

## EXHIBIT A

### Indiana State Medical Association

ANALYSIS OF DECREASE IN ASSETS, ALL FUNDS, YEAR ENDED DECEMBER 31, 1944

| | | | |
|---|---|---|---|
| **TOTAL ASSETS, DECEMBER 31, 1944—Exhibit B** | | | $45,091.95 |
| **TOTAL ASSETS, DECEMBER 31, 1943** | | | 53,145.85 |
| **NET DECREASE** | | | **$ 8,053.90** |
| Arising from the following sources: | | | |
| Excess of operating cash disbursements over operating cash receipts, General Fund, year ended December 31, 1944: | | | |
| Receipts—Exhibit C | $34,086.77 | | |
| Disbursements—Exhibit C | 38,752.67 | | |
| | | **$4,665.90** | |
| Less: Receipts arising from loan from Medical Defense Fund | | **2,000.00** | |
| | | **$6,665.90** | |
| Excess of operating disbursements over operating receipts, THE JOURNAL of The Indiana State Medical Association, year ended December 31, 1944: | | | |
| Receipts—Exhibit D | $25,485.16 | | |
| Disbursements—Exhibit D | 23,976.66 | | |
| | | 1,508.50 | |
| Less: Receipts arising from loan from Medical Defense Fund | | **3,000.00** | |
| | | **1,491.50** | |
| Excess of operating receipts over operating disbursements, Medical Defense Fund, year ended December 31, 1944: | | | |
| Receipts—Exhibit E | $ 2,788.75 | | |
| Disbursements—Exhibit E | 7,685.25 | | |
| | | **4,896.50** | |
| Add: Disbursements arising from loans to The Indiana State Medical Association and THE JOURNAL of The Indiana State Medical Association | | 5,000.00 | |
| | | 103.50 | |
| **Total Net Decrease** | | | **$ 8,053.90** |

## EXHIBIT B

STATEMENT OF ASSETS, ALL FUNDS, AT DECEMBER 31, 1944

| | | | |
|---|---|---|---|
| **General Fund:** | | | |
| Cash on deposit—Exhibit C | | $ 465.91 | |
| Petty cash fund | | 200.00 | |
| Investments: | | | |
| Marion County Flood Prevention bonds | $ 3,000.00 | | |
| Indianapolis City Hospital bonds | 5,000.00 | | |
| United States Treasury bonds | 13,000.00 | | |
| United States Savings bonds | 5,000.00 | | |
| | | 26,000.00 | |
| | | 26,665.91 | |
| Less: Loans payable to Medical Defense Fund | | 2,000.00 | |
| Total General Fund | | | $24,665.91 |
| **The Journal of The Indiana State Medical Association:** | | | |
| Cash on deposit—Exhibit D | | $ 2,894.32 | |
| Less: Loans payable to Medical Defense Fund | | 3,000.00 | |
| Total JOURNAL deficit | | | **105.68** |
| **Medical Defense Fund:** | | | |
| Cash on deposit—Exhibit E | | 531.72 | |
| Investments: | | | |
| Marion County Flood Prevention bonds | $ 2,000.00 | | |
| United States Treasury bonds | 5,000.00 | | |
| United States Savings bonds | 5,000.00 | | |
| United States baby bonds | 3,000.00 | | |
| | | 15,000.00 | |
| | | 15,531.72 | |
| Due from General Fund | 2,000.00 | | |
| Due from THE JOURNAL of The Indiana State Medical Association | 3,000.00 | | |
| | | 5,000.00 | |
| | | | 20,531.72 |
| **Total Assets, All Funds—Exhibit A** | | | **$45,091.95** |

## EXHIBIT C

COMPARATIVE STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS, YEARS ENDED DECEMBER 31, 1944, AND DECEMBER 31, 1943

| | *Year Ended December 31, 1944* | *Year Ended December 31, 1943* | Increase **Decrease** |
|---|---|---|---|
| CASH BALANCE AT BEGINNING OF YEAR | $ 5,131.81 | $10,975.14 | **$ 5,843.33** |
| **Receipts:** | | | |
| Membership dues | 23,288.50 | 23,132.00 | 156.50 |
| Income from exhibits | 7,575.00 | 5,455.00 | 2,120.00 |
| Petty cash refund—contra | ..... | 300.00 | **300.00** |
| Miscellaneous refunds | 3.30 | 45.50 | **42.20** |
| Beachton Court Liquidation Trust distribution | ..... | 35.80 | **35.80** |
| Interest income: | | | |
| United States Treasury bonds | 368.75 | 368.75 | ..... |
| United States Savings bonds | 125.00 | 87.50 | 37.50 |
| Indianapolis, Indiana, City Hospital bonds | 200.00 | 200.00 | ..... |
| Marion County, Indiana, Flood Prevention bonds | 127.50 | 127.50 | ..... |
| Instructional courses—annual session | 145.00 | 169.25 | **24.25** |
| Refund on convention expense | 193.72 | 156.67 | 37.05 |
| Industrial health conference | 60.00 | ..... | 60.00 |
| Funds transferred from Medical Defense Fund | 2,000.00 | ..... | 2,000.00 |
| | $34,086.77 | $30,077.97 | $ 4,008.80 |
| BEGINNING BALANCE PLUS CASH RECEIPTS | $39,218.58 | $41,053.11 | **$ 1,834.53** |
| **Disbursements:** | | | |
| Transfer of applicable portion of dues to The JOURNAL of The Indiana State Medical Association — Exhibit D | $ 6,768.00 | $ 6,638.00 | $ 130.00 |
| Medical Defense Fund — Exhibit E | 2,460.00 | 2,414.25 | 45.75 |
| Headquarters office expense | 12,064.95 | 10,608.60 | 1,456.35 |
| Publicity committee | 2,051.00 | 394.96 | 1,656.04 |
| Public policy | 283.27 | 1,973.40 | **1,690.13** |
| Council | 6,241.36 | 6,153.25 | 88.11 |
| Officers | 313.39 | 521.20 | **207.81** |
| Rent | 500.00 | 500.00 | ..... |
| Annual session | 4,957.20 | 4,049.86 | 907.34 |
| Miscellaneous committees | 2,882.11 | 1,996.07 | 886.04 |
| Federal old age benefit tax | 76.39 | 64.21 | 12.18 |
| Military dues refunds | 30.00 | 282.50 | **252.50** |
| Petty cash refund—contra | ..... | 300.00 | **300.00** |
| Other refunds | 25.00 | 25.00 | ..... |
| Instructional course expense | 100.00 | ..... | 100.00 |
| | $38,752.67 | $35,921.30 | $ 2,831.37 |
| **Cash Balance at End of Year** | $ 465.91 | $ 5,131.81 | **$ 4,665.90** |

*(Exhibit B)*

## EXHIBIT D

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS, YEAR ENDED DECEMBER 31, 1944

**THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION**

| | | |
|---|---|---|
| BALANCE, JANUARY 1, 1944 | | $ 1,385.82 |
| **Receipts:** | | |
| Subscriptions—members—Exhibit C | $ 6,768.00 | |
| Subscriptions—non-members | 265.50 | |
| Advertising | 15,207.55 | |
| Collection on accounts receivable | 140.50 | |
| Single copy sales | 26.20 | |
| Electrotypes | 77.41 | |
| Funds transferred from Medical Defense Fund | 3,000.00 | |
| Total receipts—Exhibit A | | 25,485.16 |
| | | 26,870.98 |
| **Disbursements:** | | |
| Editorial and management salaries | 9,628.31 | |
| Printing | 10,682.64 | |
| Office postage | 210.00 | |
| Journal postage | 552.97 | |
| Press clippings | 54.91 | |
| Electrotypes | 782.32 | |
| Telephone and telegraph | 172.80 | |
| Office rent and electricity | 540.99 | |
| Office supplies | 634.31 | |
| Advertising commissions | 440.12 | |
| Federal O.A.B. tax | 55.49 | |
| Expenses—editor and editorial board | 140.93 | |
| Sundry | 80.87 | |
| Total disbursements—Exhibit A | | 23,976.66 |
| **Balance, December 31, 1944—Exhibit B** | | **$ 2,834.32** |

## EXHIBIT E

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS YEAR ENDED DECEMBER 31, 1944

**MEDICAL DEFENSE FUND**

| | | | |
|---|---|---|---|
| BALANCE, JANUARY 1, 1944 | | | $ 5,428.22 |
| **Receipts:** | | | |
| Transfer of applicable portion of dues from the General Fund—Exhibit C | | $ 2,460.00 | |
| Interest income: | | | |
| U. S. Treasury bonds | $156.25 | | |
| U. S. Savings bonds | 87.50 | | |
| Marion County Flood Prevention bonds | 85.00 | | |
| | | 328.75 | |
| Total receipts—Exhibit A | | | 2,788.75 |
| | | | $ 8,216.97 |
| **Disbursements:** | | | |
| Attorney's fee | | 1,800.00 | |
| Malpractice fees | | 850.00 | |
| Treasurer's bond | | 15.00 | |
| Printing | | 20.25 | |
| Funds transferred to General Fund | | 2,000.00 | |
| Funds transferred to THE JOURNAL of The Indiana State Medical Association | | 3,000.00 | |
| Total disbursements | | | 7,685.25 |
| **Balance, December 31, 1944—Exhibit B** | | | **$ 531.72** |

A. F. WEYERBACHER, M.D., *Treasurer.*

## MEDICAL ECONOMICS COMMITTEE

(No report received.)

## CHAIRMAN OF THE COUNCIL

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

Detailed reports of the regular meetings held by the Council during the past year were published in the November, 1944, and the March, 1945, issues of THE JOURNAL. Minutes of the special called meetings of the Council, which were held on December 10, 1944, and on February 11, 1945, were printed in the January, 1945, and March, 1945, issues of THE JOURNAL. Therefore, your chairman at this time presents only a summary of the outstanding subjects which were discussed and the actions taken by the Council.

### FIRST MEETING, INDIANAPOLIS, OCTOBER 3, 1944

The meeting was called to order by Dr. Floyd T. Romberger, chairman, at 12:30 P.M., in the Kneipe Room of the Murat Temple, Indianapolis. Roll call showed all thirteen councilors present. In addition to the councilors, the members of the Executive Committee, a member of the Board of Trustees of the American Medical Association, the delegates to the American Medical Association, the General Arrangements Committee chairman, the Legislative Committee chairmen, and the officers of the state medical association were present.

Councilor reports as printed in the September, 1944, issue of THE JOURNAL and in the *Handbook* of the House of Delegates were accepted unanimously by the Council with no additions.

Reports were received from the Auditing Committee, from the Executive Committee on "malpractice insurance," from the Permanent Study Committee on Health Insurance, and upon legislative activities.

#### Health Insurance

Announcement made that Dr. F. S. Crockett had been appointed chairman of the special reference committee which would consider the report of the Permanent Study Committee on Health Insurance.

#### Raise in Dues

The Council recommended to the House of Delegates that "a war assessment of five dollars per member per year, beginning January 1, 1945, for the duration of the war and one year thereafter" be made.

#### JOURNAL Staff Elections

Dr. E. M. Shanklin was re-elected unanimously as editor of THE JOURNAL for 1945.

Dr. Bert Ellis and Dr. Charles N. Combs were elected members of the Editorial Board, to serve for three years.

#### Radio Programs—Commercial Sponsor

Dr. Homer Hamer, chairman of the Bureau of Publicity, discussed the matter of commercial sponsorship of radio programs. Following discussion by Dr. John Ray Newcomb, "Doctor Goodhealth" on the program, and Dr. R. L. Sensenich, the Council authorized the Bureau of Publicity and Dr. Newcomb to make further study of the matter, with the understanding that the Council was not opposed to having a commercial sponsor for the program.

#### State Board of Health Postwar Program

This was to be presented to the House of Delegates for consideration.

### SECOND MEETING, INDIANAPOLIS, OCTOBER 5, 1944

The Council was convened immediately following the adjournment of the House of Delegates on October 5, 1944, in the Riley Room, Claypool Hotel, Indianapolis, with Dr. Floyd T. Romberger presiding. Roll call showed twelve councilors present, along with the officers of the state association, members of the Executive Committee, and a member of the Board of Trustees of the American Medical Association.

#### Special Meeting of the House of Delegates

November 12, 1944, was set as the date for a special meeting of the House of Delegates, at which time the subject of health insurance was to be considered further.

#### Industrial Health Conference

Dr. E. S. Jones, chairman of the Committee on Industrial Health, discussed "future industrial health conferences" with the Council. The Council approved holding such a conference in 1945.

### SPECIAL MEETING, INDIANAPOLIS, DECEMBER 10, 1944

This meeting was called to consider appointments to the Health Insurance Committee, as authorized by the House of Delegates at its special meeting on November 12. The meeting was called to order in the Harrison Room, Columbia Club, Indianapolis, at 2:15 P.M. by Dr. Floyd T. Romberger, chairman, with ten members of the Council and one councilor-elect, and the officers and Executive Committee of the state medical association present.

Preliminary statement made by Dr. J. T. Oliphant, retiring president, that he and Dr. N. K. Forster, incoming president, had determined upon the policy for making up this special insurance committee, and desired the suggestions and help of the Council. Each councilor then suggested names from his district for membership on the committee.

#### Allen County Membership Problem

Question in regard to membership referred to the Council in a communication from Dr. A. Jerome Sparks. The Council stated that membership problems were essentially local in nature, and according to Section 4, Chapter X, of the By-Laws, "Each county medical society shall be the judge of the qualifications of its own members."

#### Council on Medical Service and Public Relations of the American Medical Association

Request that Thomas A. Hendricks, executive secretary of the Indiana State Medical Association, serve on a part-time basis as secretary of the new

Council on Medical Service and Public Relations received from the American Medical Association. Such an arrangement was approved by the Council with the understanding that the Executive Committee would handle the details of such an arrangement.

MIDWINTER MEETING, INDIANAPOLIS, JANUARY 21, 1945

Dr. Floyd T. Romberger, Lafayette, chairman, called the midwinter meeting of the Council to order at 9:40 A.M. at the Claypool Hotel, with the roll call showing eleven councilors, the officers, the members of the Executive Committee, and the chairmen of the Legislative Committee present.

**Health Insurance Committee**

Dr N. K. Forster, president, announced the appointment of the Committee on Prepayment of Medical and Surgical Care, consisting of twenty-one members, with Dr. W. U. Kennedy, of New Castle, serving as chairman.

**Other Committee Recommendations**

Dr. Forster recommended changes in functions and scope of activities of several other committees, and also suggested an increase in salary for THE JOURNEL personnel.

**Other Reports of Officers**

Dr. A. F. Weyerbacher, treasurer, and Dr. Cleon A. Nafe, chairman of the Executive Committee, also made reports.

**Group Malpractice Insurance**

Dr. Nafe reported that the St. Paul Mercury Indemnity Company had written 275 policies for Indiana physicians.

**Plans for 1945 Annual Session**

Preliminary report for the 1945 annual session to be held at French Lick, October 2, 3, and 4 presented to and approved by the Council.

**Inter-Professional Health Council**

Dr. F. S. Crockett, of Lafayette, was reappointed chairman, and Dr. A. M. Mitchell, of Terre Haute, was made a member to represent the Indiana State Medical Association on the Inter-Professional Health Council.

**Contract with Editor of THE JOURNAL**

Contract with the editor of THE JOURNAL was renewed for 1945.

**Nominations for Editorial Board**

Dr. James F. Balch, of Indianapolis; Dr. F. R. N. Carter, of South Bend, and Dr. E. L. Bulson, of Fort Wayne, were nominated. Two places are to be filled on the Editorial Board at the meeting of the Council during the annual session.

**Ohio River Valley Water Sanitation Compact**

Resolution passed by the Ohio State Medical Association, urging the Pennsylvania and Virginia State Medical Associations to lend their support to the approval of the Ohio River Valley Water Sanitation Compact, brought to the attention of the Council. The Council went on record expressing favor of this resolution.

**Legislative Matters**

Dr. Beatty and Dr. Wright, co-chairmen of the Committee on Public Policy and Legislation, made a report before the Council on bills that are to be introduced in the 1945 legislature.

**Elections for 1945**

Dr. C. A. Nafe and Dr. C. H. McCaskey were re-elected members of the Executive Committee for 1945.

Dr. Floyd T. Romberger was unanimously re-elected chairman of the Council for 1945.

**Luncheon Meeting**

*Industrial Tuberculosis Survey.* Members of the Board of Directors of the Indiana Tuberculosis Association appeared before the Council and explained the use of mobile tuberculosis screening units. The Council approved this survey.

SPECIAL MEETING, INDIANAPOLIS, FEBRUARY 11, 1945

The Council, the Executive Committee, and the Committee on Public Policy and Legislation held a special meeting at the Columbia Club, Indianapolis, on February 11, 1945, to consider matters pending in the legislature. The meeting was called to order at 1:30 P.M. by Dr. Floyd T. Romberger, chairman, with nine councilors, members of the Executive Committee and Committee on Public Policy and Legislation, officers of the association, members of the Indiana State Board of Medical Registration and Examination, and representatives from the Indiana State Board of Health present.

Pending legislation was reviewed by Dr. Norman M. Beatty and Dr. J. Willian Wright, co-chairmen of the Legislative Committee.

FLOYD T. ROMBERGER, *Chairman.*

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## REPORTS FROM DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

No meeting of the First District Medical Society has been held this year, and the same officers will hold over until such a time as a meeting is held.

I. C. BARCLAY, M.D., *Councilor.*

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SECOND COUNCILOR DISTRICT

Some of our members have died during the past year, others are worn-out, and some have cut down their practice in the hope of conserving themselves so that they can last longer. The Army and Navy clamor for more doctors; war agencies want doctors; and the veterans' hospitals want more and better-trained physicians. Men come home by the thousands, but none or very few doctors return to private practice, at least not in our neighborhood.

The returned veterans with illness of body and mind are counting on General Omar Bradley to

bring them at once a sick-man's utopia. How General Bradley is to do this I do not know. Intelligent young women in good health and blessed with energy can, and have, become useful nurses aids within a few weeks, thereby increasing the services of graduate nurses, but wishful thinking will not produce doctors, whose training requires years of preparation. Our university medical school has announced a lack of medical students to make up its minimum quota; this number will not replace the doctors lost by wear and tear.

It appears that the "upper bracket" has failed us. No right man is at the top. Or, if so, his work and wishes have been stymied by other uninformed or misinformed individuals or other interests. Someone should come out of the "wilderness."

Little has been done by our district and county medical organizations, although necessary business has been carried on by the members of county societies.

Opinions and views are in a fluid state, with little crystallization of ideas. There are two schools of medical opinion. One group feels that we should do nothing radical until the "boys come home." The other group fears that we will miss the starting gun, and thus fail to run in a race that probably should be won for the "boys" before they return. However, there will always be a sweet corn and watermelon season in southern Indiana, and later pawpaws and persimmons. Mayhap the doctor near the Ohio River was right when in 1937 he said, "What medicine really needs is a good 'lettin' alone.' "

H. C. WADSWORTH, M.D., *Councilor.*

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### THIRD COUNCILOR DISTRICT

The physicians of the Third Councilor District, located in the hills of southern Indiana and in the valleys along the Ohio, are on the job on the home front and on the war front. The entire district is receiving excellent medical care from those on the home front, and we have reason to believe that the district's record of medical enlistments and services in the armed forces is second to none in the state.

No Third District meeting was held in 1943. In 1944 a meeting was held at New Albany, which was probably the best-attended meeting in the history of the district society. Dr. Lyman T. Meiks, resident pediatrician at the Riley Hospital, Indianapolis, spoke on "The Clinical Aspect of Poliomyelitis," which was enthusiastically received by the society. Dr. Jacob T. Oliphant, president, and Thomas A. Hendricks, secretary of the Indiana State Medical Association, ably discussed the present medical trends and problems. We were also honored by the presence of Dr. Carl H. McCaskey and Dr. Karl Ruddell, past presidents of the Indiana State Medical Association, and Dr. Cleon A. Nafe, chairman of the Executive Committee.

The District Councilor presented "An Eight-Point Plan of 'Boot Training' for the Home Guard of American Medicine," urging the doctors to take more interest in county, district, and state medical organization work. Possibly this had something to do with the district's splendid representation at the last state meeting at Indianapolis. Definitely, the county societies of the district are alert and are taking more interest in the problems of American Medicine. Harrison, Floyd, and Clark counties held a splendid joint meeting on "Prepaid Medical Care," and all the other counties met and sent instructed representatives to the House of Delegates. The Floyd County Medical Society is devoting each monthly meeting in 1945 to a discussion of medical legislation, organization, and economic problems. This year the district is well represented on the roster of committees of the state association. Yes, the Third District is on the job, on the organization front.

Dr. Percy R. Pierson, of New Albany, and Dr. Marvin L. McClain, of Scottsburg, the president and the secretary of the Third District Medical Society, have announced that the 1945 annual meeting will be held at Scottsburg, Wednesday, September 26, and that they are planning a program that should attract every member in the district.

Your councilor regrets to report that the grim reaper has taken five members from the Third District. Drs. Walter A. Hall, of New Albany; Claude B. Paynter, of Salem; Morton F. Wolfe, of New Albany; Thomas Martin Smith, of Jeffersonville; and Frank A. May, of Palmyra, are those whose life work ended during the past year. Each one was a credit to the medical profession; a true disciple of Aesculapius, and honored and respected by all who knew them.

We are sorry that, due to the O.D.T. ruling, the Third District may not have the pleasure and privilege of entertaining the state association meeting at French Lick Springs this year, but, if not, we hope that we will be seeing you at French Lick in 1946.

AUGUSTUS P. HAUSS, M.D., *Councilor.*

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### FOURTH COUNCILOR DISTRICT

The Fourth Councilor District of the Indiana State Medical Association was the guest of the Jefferson County Medical Society, and met at the Clifty Inn, at Madison. The meeting was well attended considering the various influences that reduce an audience on such occasions.

Columbus was selected as the meeting place for next year, and the following officers were elected:

President_____Dr. R. B. Hart, Columbus.
Vice-president____Dr. L. H. Osterman, Seymour.
Secretary-treasurer_Dr. Lowell Beggs, Columbus.

The scientific discussions of the afternoon were informative and interesting. All social aspects of the Fourth District have been discontinued for the duration.

CHARLES OVERPECK, M.D., *Councilor.*

### FIFTH COUNCILOR DISTRICT

The Fifth Councilor District Medical Society as an organization has held no formal meeting during the year. However, the members of the district have met on several informal occasions for meetings sponsored by various commercial organizations or institutions in the district. One of these meetings was held on July 20, when we were guests of the Wabash River Ordnance Works, at Newport. The district society also was invited to attend the opening of the eighty-five-bed hospital at the Vigo Ordnance Chemical Warfare Plant, at Terre Haute.

The county medical societies in the district are holding their regular meetings despite the stress of wartime conditions.

A. M. Mitchell, M.D., *Councilor.*

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### SIXTH COUNCILOR DISTRICT

Absence of practically all of our young men, with the increased burdens on the stay-at-homes, has sharply decreased our usual activities. The Sixth Councilor District Society held a business meeting only.

Considerable interest is shown in the proposed insurance plan, the need for which has been emphasized at our meetings.

During the year the former councilor, Dr. Samuel Kennedy, who had served us so long and faithfully, found that his health made it necessary for him to retire. For many years Doctor Sam took an active part in every medical activity, and his retirement brought sincere regret. Dr. W. U. Kennedy, of New Castle, was elected to succeed him.

The Sixth District has had no unusual problems, but is anticipating the return of its young men.

New hospitals are announced in Hancock and in Rush counties, but will not be built until the war is over. We shall then have modern hospitals in all but two of our counties, and both of them are near excellent hospitals. This District does not look with favor on federal help, feeling themselves capable of supplying their own needs and conducting their own affairs.

The district has been honored by the election of Doctor Ferrell to the presidency of the association. The same energy heretofore shown by him in district affairs promises a forceful administration next year. The district will loyally and enthusiastically support him.

Walter U. Kennedy, M.D., *Councilor.*

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### SEVENTH COUNCILOR DISTRICT

The Seventh District Medical Society held its fall meeting in October, at the American Legion Home, at Franklin. Dr. Oscar T. Scamahorn, of Pittsboro, is President-elect, and Dr. Norman S. Loomis, of Indianapolis, is Secretary-Treasurer. Dr. W. L. Portteus was elected councilor for a regular term, after having served as councilor pro tem during Dr. Cyrus J. Clark's unexpired term.

The afternoon session was in the charge of the Indiana Trudeau Society, and papers on the various aspects of tuberculosis were read. The evening program was given by Major Blocker, chief of the Plastic Service at Camp Atterbury, and his staff.

Each county society in this district has continued regular meetings with the major interest being directed toward the study of some sort of prepayment medical insurance plan.

W. L. Portteus, M.D., *Councilor.*

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### EIGHTH COUNCILOR DISTRICT

The societies of the Eighth District have continued regular meetings during the past year. Chief interest now seems to be concerning partial demobilization of medical officers from military service.

The annual meeting was held at the Winchester Country Club on June 13, 1945. Randolph County Society members, under the direction of Dr. C. E. Martin and Dr. Ivan E. Brenner, provided an excellent dinner and an instructive program. Dr. W. D. Gatch read a paper entitled "Medical Education." He placed emphasis on the importance of the general practitioner and his place in the specialization of medicine. He suggested that a specialty of general practice be set up in medical schools and medical organizations. Dr. Cleon Nafe reported on the recent activities of the state organization.

The officers elected for the coming year were: Dr. Bruce W. Stocking, President, and Dr. Anson Hurley, Secretary-Treasurer.

The 1946 meeting will be held at Muncie.

E. H. Clauser, M.D., *Councilor.*

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### NINTH COUNCILOR DISTRICT

The Ninth Councilor District held its annual 1945 meeting at Forest Park, Noblesville, on May eighth, with the Hamilton County Medical Society as host.

Following a pleasant luncheon the business of the district was discussed and the remaining hours of the afternoon were spent in an agreeable and instructive round-table discussion of local, state, and national problems as they relate to medical practice. So highly was this enjoyed by all that it was felt that such a session should feature all future meetings of the district.

Drs. Connoy and Havens, along with their committees, deserve high praise for their activity during our present time of stress. The district will hold its 1946 meeting in Lebanon, as the guest of the Boone County Medical Society.

Floyd T. Romberger, M.D., *Councilor.*

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### TENTH COUNCILOR DISTRICT

Tenth District officers elected at a combined meeting of the Tenth District Medical Society and the Lake County Medical Society, on May ninth, were Dr. L. J. Danieleski, succeeding Dr. F. F. Boys as president, and Dr. M. B. Gevirtz, secre-

tary-treasurer. Other meetings held during the year included a dinner meeting on May eleventh at the Woodmar Country Club, Hammond, when industrial rehabilitation was discussed by Dr. Robert J. Bennett, chief surgeon of the Carnegie Illinois Steel Corporation, Dr. Philip H. Becker, superintendent of Parramore Hospital, Dr. Italo Volini of Loyola University, and Dr. David Slight of the University of Chicago School of Medicine. Papers featured industrial rehabilitation of tuberculous patients, heart cases, neuropsychiatric cases, and fractures.

Again on September twentieth, an afternoon and evening meeting was held at Phil Schmidt's, in North Hammond, with one hundred twenty-eight doctors in attendance. Colonel John R. Hall, M.C., commanding officer of Gardiner General Hospital, and a group of his assistants, demonstrated with patients the many activties of the Medical Corps and its hospital treatment of patients at Gardiner General. This was considered an outstanding meeting of the Tenth District.

The Lake County Medical Society lost its executive secretary, Mr. Rollen Waterson, who has gone to Oakland, California, to assume the duties of executive secretary for the Alameda County (California) Medical Association. Mr. Rollis Weesner, for a long time associated with the Hammond Public Schools and active in Calumet civic affairs, was appointed executive secretary to succeed Mr. Waterson.

This district maintains its aggressive opposition to political medicine, and reconfirms its pledge to provide the best possible medical service to its citizens, with real interest and support of public health measures that contribute to the general good—the most recent expression being a mass x-ray survey program for the detection of tuberculosis.

W. H. Howard, M.D., *Councilor*

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### ELEVENTH COUNCILOR DISTRICT

Each county in the district is functioning normally and effectively, and we had a very interesting, instructive, and well-attended district meeting at Logansport in May.

C. S. Black, M.D., *Councilor.*

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### TWELFTH COUNCILOR DISTRICT

Some of our members are beginning to trickle back from the services. It is only a trickle thus far, and chiefly in Fort Wayne, but we hope it is an indication of better things to come, soon. We are as happy to have them as they are to be back with us.

Scientific meetings in the district have suffered a little because of the difficulty of preparing programs. However, since even the medical journals ordinarily flooded with articles for publication are begging for material these days, the situation is highly excusable. The members are doing a splendid job in line of duty, and patients are liberal with their praise for the medical profession. Keep up the good work until the boys get home.

A. Jerome Sparks, M.D., *Councilor.*

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### THIRTEENTH COUNCILOR DISTRICT

The Thirteenth District Medical Society will have its next annual meeting on November 14, 1945, in South Bend. We are having some outstanding speakers, one of whom is nationally known. We cordially invite members of the state society to be with us that afternoon and evening.

We are glad to report that Dr. L. W. Vore, the District Society President, who has been ill for some months, is now improved and has resumed practice. Four members have been discharged recently from the service, and we hope that this is the beginning of the early return of all of our men.

Alfred Ellison, M.D., *Councilor.*

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## COMMITTEE ON CREDENTIALS

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

The Committee on Credentials served in its official capacity three times during the past year, that is, at the regular meetings of the House of Delegates which were held on October 3 and 5, 1944, during the annual session, and at the special meeting of the House of Delegates on November 12, 1944.

In accordance with the Constitution and By-Laws of the Indiana State Medical Association, each county medical society must certify its delegates and alternates previous to the annual session. A postal-card notification signed by the secretary of the local county medical society and sent to the headquarters' office is sufficient certification. If you have not yet taken this action in your society, we urge that this be done immediately.

W. E. Amy, M.D., *Chairman,*
G. T. Bowers, M.D.,
J. R. Crowder, M.D.,
G. S. Fessler, M.D.,
C. P. Fox, M.D.

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## COMMITTEE ON POSTWAR MEDICAL SERVICE

(No report received.)

## EXECUTIVE COMMITTEE

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

### I. PREPARATIONS FOR 1946

For business, the year 1945 has meant a start toward reconversion; for the armed forces, it has meant victory; and for medicine, it has meant the beginning of a period of transition. During the past twelve months your Executive Committee has attempted to keep pace with the changing conditions inevitable to this transition; to keep informed in regard to important happenings, facts, and problems during this period; and to do something about it all in preparation for 1946. It is doubted whether your organization has ever had a busier and, in some respects, a more significant year.

A new public health program, enacted by a health-conscious legislature, under the sponsorship of a health-minded administration; the trials, errors, and tribulations that mark the establishment of a voluntary prepayment medical care plan; and what was perhaps the most important and effective action taken by the Executive Committee—the appeal for the speedy return to civilian practice of doctors in the armed forces whose services are no longer needed for national security—these are only three of the important matters affecting the profession and the public welfare which have faced the officers and Executive Committee during the past year. To get the complete picture, your committee suggests that you read this report and those of the officers and other committees of the association. By doing this each physician should be reasonably prepared to play his part in meeting the problems which are bound to confront Indiana Medicine in 1946.

### II. SPECIAL ACTIVITIES OF STATE ASSOCIATION DURING 1945

1. *Constructive program of medical care.* The Council on Medical Service and Public Relations of the American Medical Association, on July 21, 1945, presented to the profession and to the American people a fourteen-point program for medical care of the nation. In conjunction with the release of this program the Council on Medical Service and Public Relations has made a request that each state medical society prepare ways and means of carrying out this program. The A. M. A. Council suggests that certain functions might be assigned to committees already in existence, while it might be well to create other special committees to carry out other functions of the program. The Council on Public Relations, of the state association, has been created and has taken action on this program, which is recommended to the attention of each county society.

2. *Release of Indiana physicians from armed forces.* Taking the initiative, the Executive Committee of the Indiana State Medical Association, at its meeting on June 17, 1945, passed a resolution asking that physicians who are no longer essential to national security be released from the armed forces and returned to civilian practice as rapidly as possible. Copies of this resolution were carried in the press, not only in Indiana but throughout the country, were sent to the American Medical Association and state medical societies, to the Indiana delegation in Congress, and to every Indiana physician serving in the armed forces. The response was immediate and overwhelmingly favorable. An investigation of the matter was asked for by Congress. (Similar action was taken by Connecticut and other state societies.) The Council on Medical Service and Public Relations of the American Medical Association, in its constructive program for medical care, listed the release of physicians from the armed services who are no longer needed for military use as one of the major points of its fourteen-point program, and scores of letters were received from doctors who are serving in the armed forces. It is felt that the Indiana resolution played no little part in this rising national demand for action by those in authority upon this subject. It is hoped that definite action will be forthcoming, and that substantial numbers will be released for civilian practice as speedily as possible.

3. *Prepayment medical care program.* The constructive program for medical care, prepared by the Council on Medical Service and Public Relations and approved by the Board of Trustees of the American Medical Association, makes the following statements in regard to voluntary hospital and medical care programs:

1. Increased hospitalization insurance on a voluntary basis.
2. The development in or extension to all localities of voluntary sickness insurance plans and provision for the extension of these plans to the needy, under the principles already established by the American Medical Association.
3. The provision of hospitalization and medical care to the indigent by local authorities under voluntary hospital and sickness insurance plans.

The Committee on Prepayment of Medical and Surgical Care, with Dr. W. U. Kennedy, of New Castle, serving as chairman, has worked for many months to prepare a plan for Indiana, to be submitted to the House of Delegates. Your committee suggests that every physician should be familiar with the work of Dr. Kennedy's committee and its recommendations, which are nearing completion and will be released shortly. A special meeting of the House of Delegates probably will be called before the first of the year to consider these proposals.

4. *Public health program for the State of Indiana.* "The most progressive public health pro-

gram in the nation" is the term that has been used for the legislative program enacted by the 1945 session of the legislature for the State of Indiana. Every physician in the state should be familiar with the broad points of this setup, which have been discussed on numerous occasions in THE JOURNAL and in reports of the Committee on Public Policy and Legislation of the state medical association. The administration of this program comes under the direction of Dr. Leroy E. Burney, new health commissioner of Indiana, an Indiana man who returns to his state well qualified for the position by background, training, and experience.

5. *Employment of assistant executive secretary.* With the increased demand on all sides for extended activity in the field of public relations, and with the employment of Thomas A. Hendricks, executive secretary, as the executive head of the new Council on Medical Service and Public Relations of the American Medical Association, Mr. Ray E. Smith, of Indianapolis, was appointed on June 1, 1945, as assistant executive secretary of the Indiana State Medical Association. This was done in accordance with authority given to the Executive Committee by the Council at its special meeting on December 10, 1944. Mr. Smith is serving as executive secretary of the Indianapolis Medical Society, as well as assistant secretary of the state medical association, dividing his time between the two offices. This will enable the society to intensify and to amplify its efforts, particularly in its public relations work.

6. *Conference of state medical society presidents.* The presidents of seventeen state medical societies, including Dr. N. K. Forster, of Indiana, were invited to attend a conference sponsored by the Michigan State Medical Society and Michigan Medical Service, at Detroit, Michigan, April 27 and 28, 1945. Doctor Forster will discuss this conference in his presidential address.

In June ten presidents met at Denver, Colorado, representing the western and Pacific coast states. This makes a group of twenty-six presidents who are meeting and discussing these problems.

7. *Council on State Organizations for Indiana.* Dr. Eugene Boggs and Dr. John D. Van Nuys have been appointed to represent the Indiana State Medical Association upon the Council on State Organizations, which was organized during the year under the direction of the Indiana State Conference on Social Work. Reports of activities of this Council have been made to the Executive Committee from time to time by Dr. Van Nuys and Dr. Boggs.

8. *Annual registration fee.* The Executive Committee recommends to the House of Delegates that the Legislative Committee be authorized to present a bill at the next session of the General Assembly, providing for an annual registration fee, to give the newly-created State Board of Medical Registration and Examination sufficient funds to carry on its duties properly.

## III. REGULAR ADMINISTRATIVE FUNCTIONS OF EXECUTIVE COMMITTEE

The many usual problems and routine duties seem to have multiplied rather than lessened for medical organizations during the war. In addition to the several all-important special jobs which the profession has faced during the past year, the most outstanding of which already have been discussed, the regular duties of the committee fall generally into three parts:

A. Administrative.
B. Management of THE JOURNAL.
C. Administration of Medical Defense Fund.

### (A) ADMINISTRATIVE DUTIES.

1. *Heavy monthly programs faced by committee.* The program of business faced by the Executive Committee at each of its monthly meetings has been unusually heavy during the past year. This has necessitated the holding of innumerable informal meetings and conferences in addition to the regular meetings in order to get the job done. At nearly all of the regular meetings chairmen and members of one or more of the key committees of administrative groups of the association have been invited to lunch with the Executive Committee and discuss special, individual problems. Such meetings have been held with important committees of the association, such as the Bureau of Publicity, Committee on Prepayment of Medical and Surgical Care, Committee on Public Policy and Legislation, Committee for the Study of Lay Activity in Medical Practice, Committee on Postwar Medical Service, and the Medical Relief Committee. In addition, meetings have been held with official agencies having to do with medical problems, among them the members of the State Board of Medical Registration and Examination and the State Board of Health.

2. *Membership.* Membership figures of the association for 1945 stand as the highest in the association's history. A comparison of the figures for 1942, 1943, 1944, and 1945 follows:

| *Year....* | *Number of Physicians in Indiana* | *Regular Members* | *Honorary Members* | *Total Members* |
|---|---|---|---|---|
| 1942 | 4,132 | 3,081 | 110 | 3,191 |
| 1943 | 4,165 | 2,983* | 110 | 3,093 |
| 1944 | 4,165 | 3,197** | 129 | 3,326 |
| 1945 | 4,165 | 3,187*** | 142 | 3,329 |

* Includes 741 men in service who received membership gratis.

** Includes 936 men in service who received membership gratis.

*** Includes 1,019 men in service who received membership gratis.

**(B) THE JOURNAL.**

**Journal Achievements:**

Despite the stringencies of war, and the many problems encountered as a result of paper limitation, shortage of manpower, and concurrent complexities, THE JOURNAL of the Indiana State Medical Association set a record for itself during 1944. As a matter of fact, by careful planning and pruning of press orders, et cetera, it was possible to publish the largest volume in the history of the association, this being the September issue, which was devoted to the Army Air Force, and comprised one hundred ninety-six pages. The total page production for the year exceeded all former years by ninety-four pages. At that, THE JOURNAL stayed within its paper allotment except for a slight overdraft at the end of the year, which was offset by a page reduction in the first quarter of 1945, so that THE JOURNAL is again on a par with its paper quota. Recently there has also been an easing in the paper situation, which will amply provide for our requirements.

Transportation necessitated curtailment of travel, with the result that few meetings have been held, which impeded the source of Journal material, and scientific articles have not been as abundant because of the impact of the extra load carried by the physicians in civilian practice. The physicians in the armed forces have been too busy to write scientific articles, besides being somewhat restricted by military censorship, so all in all it has not been easy going for the JOURNAL staff, but, as usual, in time of need the members of the association have come to their rescue, and we have been proud of the finished product.

The editor has been somewhat hampered by the discontinuance of the Monon service between Hammond and Indianapolis, but, train or no train, THE JOURNAL achievements have been most outstanding. Perhaps the greatest sense of pride has come from those in the military, whose many letters of appreciation and commendation have been a source of joy. These men have been aware of the association's efforts in their behalf, and of the editor's attempt to keep them abreast of the times, keeping them informed of the problems that now confront the medical profession. Constant vigil is kept to forestall attempts at socialization of medicine, and to maintain a place for the men who have so nobly served their country, so that they may return to the practice they left behind.

The "Military News" section of THE JOURNAL has been particularly appreciated by the men in the armed forces, and which they say has served as a source of reference in keeping them informed as to the whereabouts of other Indiana physicians. These men have themselves been helpful in that they have contributed news items and photographs for use in these columns.

**Printing:**

C. E. Pauley & Company, Inc., continue to do THE JOURNAL printing, and have done a fine job in spite of their reduction in personnel, et cetera. There has at times been a delay in getting the magazine off the press, but there is also more press work now that more advertisers are using color.

**Journal pages printed in 1944 as compared with former years:**

| *Year* | *Reading Pages* | *Per Cent Read.* | *Adv. Pages* | *Per Cent Adv.* | *Total* | *Average Pages Per Issue* |
|---|---|---|---|---|---|---|
| 1933 | 634 | 64 | 358 | 36 | 922 | 82 |
| 1934 | 604 | 60 | 408 | 40 | 1012 | 84 |
| 1935 | 704 | 62 | 428 | 38 | 1132 | 94 |
| 1936 | 680 | 59 | 472 | 41 | 1152 | 96 |
| 1937 | 674 | 57 | 514 | 43 | 1188 | 99 |
| 1938 | 728 | 59 | 504 | 41 | 1232 | 102.6 |
| 1939 | 730 | 59 | 502 | 41 | 1232 | 102.6 |
| 1940 | 736 | 59 | 506 | 41 | 1242 | 103.5 |
| 1941 | 728 | 59 | 506 | 41 | 1234 | 102.8 |
| 1942 | 752 | 61 | 488 | 39 | 1240 | 103.3 |
| 1943 | 736 | 59 | 516 | 41 | 1252 | 104.1 |
| 1944 | 758 | 56 | 588 | 44 | 1346 | 112.1 |

**Cooperative Bureau Advertising:**

For 1944 the Cooperative Bureau advertising showed an increase of $1,666.68 over that of 1943, although a large percentage of this covered the cost of the extra color now used by many advertisers, so that our actual revenue was not as great as one might be led to believe.

For 1945, however, there has been some increase in the actual number of pages, in addition to the color used, for which we express gratitude to the Cooperative Medical Advertising Bureau.

**Journal Revenue:**

The JOURNAL advertising revenue has increased from $10,984.15 for 1942, to $15,207.55 for 1944, but printing costs and other expenses have increased correspondingly, and The Journal Fund became depleted during 1944, since no increase has been made in the membership allowance to THE JOURNAL since the original By-Laws were written. Hence, a $3,000 loan was made to THE JOURNAL from the Medical Defense Fund.

A comparison of advertising revenue for the first six months of 1945, with that of previous years, is given:

| *First six months:* | *1942* | *1943* | *1944* | *1945* |
|---|---|---|---|---|
| Bureau agency.. | $2,558.89 | $2,950.97 | $3,487.58 | $6,114.28 |
| Direct ..... | 2,554.27 | 2,347.75 | 2,507.32 | 2,766.18 |
| | $5,113.16 | $5,298.72 | $5,994.90 | $8,880.46 |

For 1946 a new advertising rate will become effective, as of January first, which will help somewhat in defraying expenses.

**Contact Your Advertisers:**

THE JOURNAL is sustained largely through the receipts from its advertisers, and, naturally, the concerns which advertise in THE JOURNAL anticipate an interest in their products. Hence, we appeal to our readers that they pay particular attention to these advertisements, and manifest their interest by requesting literature and samples offered through this medium, which will not only benefit the doctor but also the advertiser because it gives him an opportunity to exhibit his product.

**(C) MEDICAL DEFENSE ACTIVITIES.**

1. *Group malpractice insurance.* The St. Paul Mercury Indemnity Company was officially designated as the underwriter for group malpractice insurance by the Executive Committee last year.

2. *Malpractice cases.* A year ago, at the time of this report, August 1, 1944, the following fifteen cases were pending before the committee, three of which were closed during the year, leaving twelve cases still pending:

*Case No. 200*—Suit filed February 2, 1932. Pending.

*Case No. 203*—Suit filed August 22, 1934. Defendant deceased, but case still pending.

*Case No. 226*—Suit filed November 5, 1938. Suit withdrawn and another filed January 16, 1939.

*Case No. 230*—Suit filed November 18, 1939. Pending.

*Case No. 232*—Suit filed April 11, 1940. Pending.

*Case No. 239*—Suit filed May 1, 1941. Pending.

*Case No. 241*—Suit filed February 7, 1941. Pending.

*Case No. 242*—Suit filed January 28, 1942. Case venued January 10, 1944. Pending.

*Case No. 243*—Suit filed August 15, 1942. Pending.

*Case No. 244*—Suit filed March, 1942. Pending.

*Case No. 245*—(Closed) Suit filed January 30, 1942. Dismissed January 15, 1944. Expense, $50.00, paid October 10, 1944.

*Case No. 246*—Suit filed October, 1942. Pending.

*Case No. 247*—(Closed) Suit filed June 7, 1943. Settled and dismissed October 22, 1944. Expense, $50.00, paid December 6, 1944.

*Case No. 248*—(Closed) Suit filed October 9, 1943. Instructed verdict for defendant May 18, 1944. Case dismissed November 9, 1944. Expense, $150.00, paid December 20, 1944.

*Case No. 249*—Suit filed January 6, 1944. Pending.

Since August 1, 1944, and up to August 1, 1945, the following three new cases have come before the committee, making a total of fifteen cases pending at the present time as against the same number of unclosed cases at the same time last year:

*Case No. 250*—Suit filed December 7, 1944. Pending.

*Case No. 251*—Suit filed September 25, 1942. Pending.

*Case No. 252*—Suit filed August, 1944. Pending.

3. *Medical Defense Fund.* Statement, from August 1, 1944, to August 1, 1945:

| | | |
|---|---|---|
| Balance, August 1, 1944 | | $6,325.48 |
| **Receipts:** | | |
| Dues, 1—1942 member | $ .75 | |
| 1—1943 member | .75 | |
| 4—1944 members at 75c | 3.00 | |
| 3,207—1945 members at 75c | 2,405.25 | |
| | | 2,409.75 |
| Interest on bonds | | 387.50 |
| Reimbursement from General Fund of Association | | 2,000.00 |
| | | $11,122.73 |
| **Disbursements:** | | |
| Malpractice fees | $ 250.00 | |
| Salary for Association attorney | 1,800.00 | |
| Treasurer's bond | 15.00 | |
| Transfer of funds: | | |
| To THE JOURNAL | 3,000.00 | |
| To General Fund of Association | 2,000.00 | |
| | | 7,065.00 |
| **Balance in Medical Defense Fund checking account, August 1, 1945** | | $4,057.73 |

## IV. CONCLUSION

*Important problems ahead.* The heaviest burden ever placed upon them will rest with each of the eighty-three county medical societies of the state in 1946. Faced with problems, increasing daily—almost hourly—in number and importance, your Executive Committee appeals to each and every county medical society to do everything possible to hold regular meetings and maintain an active organization during the coming year. This, your committee realizes, is doubly difficult because of the fact that individual physicians are busier than ever before, but despite the working hours faced by every physician in his private practice, each must sacrifice a substantial part of his time and effort for medical organization work if the medical profession of Indiana is to continue to assume leadership and direct the destinies of Indiana Medicine in the future as it has in the past.

CLEON A. NAFE, M. D. *Chairman,*
C. H. MCCASKEY, M. D.
N. K. FORSTER, M. D.
J. E. FERRELL, M. D.
F. T. ROMBERGER, M. D.

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## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

The Committee on Public Policy and Legislation wishes to make the following report:

The committee has had the full cooperation of the various county medical societies and public officials. This year has been a momentous year in the passage of constructive public health legislation in Indiana. A full detailed report of this legislation was published in the April, 1945, issue of THE JOURNAL.

The committee has attempted to keep in close touch with pending federal legislation, and will do its best to continue to carry out the policies of the House of Delegates.

N. M. Beatty, M.D.,
J. William Wright, M.D.,
*Co-chairmen.*
George Daniels, M.D.
John Hewitt, M.D.
J. R. Doty, M.D.
M. R. Lohman, M.D.
J. S. Niblick, M.D.
Walter F. Kelly, M.D.
Robert Acre, M.D.

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## BUREAU OF PUBLICITY

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

**I. Plans for 1946**

By tradition, the Bureau of Publicity, through its contact with the press and radio and its speakers' service, has served constantly in the public relations field for the Indiana State Medical Association. Two years ago the House of Delegates of the American Medical Association created a Council on Medical Service and Public Relations, thereby recognizing the importance of public relations as an integral part in medical organization activities. To coordinate the work of the Indiana State Medical Association with that of the Council on Medical Service and Public Relations of the American Medical Association, a special committee of the state association has been appointed to consider the problems in the public relations field. To integrate the efforts of the Bureau of Publicity with those of the public relations group in the state association, the Bureau of Publicity is reorganizing its work in order to amplify its newspaper, radio, and speaking program during 1946, by the following methods:

(1) Increase the importance of radio broadcasts sponsored by the bureau.

(2) Preparation of a special news service to weekly newspapers of the state.

(3) Preparation of speakers' material upon the Wagner-Murray-Dingell Bill.

(4) Cooperation with the Committee on Industrial Health and the Mental Health Committee in supplying speakers for county medical society meetings and meetings with the laity.

(5) Appointment of Ray E. Smith, assistant secretary of the Indiana State Medical Association, as secretary of the bureau, at the suggestion and request of Thomas A. Hendricks, executive secretary. This will enable the bureau to carry on more intensively and amplify its publicity and public relations activities.

**II. Contact with the Public**

(1) *Policy in releasing news:* Weekly news releases were prepared and issued as usual by the Bureau of Publicity during the year. In addition, several special releases came under the direction of the bureau during the state meeting. However, the Bureau of Publicity does not pass on all newspaper statements and releases that come from the various committees of the Indiana State Medical Association. Thus, when the House of Delegates of the state association meets, and sometimes when the Executive Committee or Council meets, news releases appear in the papers which have not cleared through the channels of the bureau. This policy has been customary for many years, and often it has been necessary because of the time element or the urgency of the matter at hand. The bureau believes that some misunderstanding in regard to this procedure exists, and asks the House of Delegates to define the bureau's duties and powers in this respect. Is it the desire and wish of the House of Delegates that all statements or news handouts be cleared first through the bureau?

(2) *Radio:*

a. *"Dr. Goodhealth" programs:* Every Monday during the past year "Dr. Goodhealth" has been presented over WFBM in Indianapolis, with Dr. John Ray Newcomb in the title role of the "genial guide to keeping well." During the year the station generously provided an organist who plays the theme and incidental music all through the program, and we were fortunate in acquiring—gratis—the services of Mrs. Jane Kinghan, a professional actress to take the feminine roles. Men returning from active military duty have been interviewed—medical officers on their return from China, the South Pacific, Italy, France, Germany, and Russia; one from the Cabantuan Prison Camp; doctors on active duty as flight surgeons; and a flight nurse from the European theatre. During the state meeting the speakers and the incoming president were interviewed. Dr. Leroy E. Burney, the new state health commissioner, was on one program. Regular programs were based on current health problems. On July 30 the seventy-sixth consecutive program was broadcast. Many of the programs have received advance notice in the radio columns of local newspapers, and a fair amount of fan mail has been received.

b. *State programs:* Special scripts for one speaker are provided various stations in the state, and presented by local society members. Transcriptions of the Dr. Goodhealth programs have been given on the Evansville station. Stations presenting our program weekly throughout the year are:

WTRC, Elkhart.
WBOW, Terre Haute.
WSBT, South Bend.
WKMO, Kokomo.
WGBF, Evansville.

c. *Commercial sponsor:* The Council of the Indiana State Medical Association, at its regular meeting during the ninety-fifth annual session of the Indiana State Medical Association, passed the following resolution in regard to a commercial sponsor for radio programs:

> "*Commercial sponsorship of radio programs:* Dr. Homer Hamer brought up the question of having a commercial firm sponsor the 'Doctor Goodhealth' programs which are broadcast by the Indiana State Medical Association. Dr. John Ray Newcomb and Dr. R. L. Sensenich discussed this question, and the Council authorized the Bureau of Publicity and Dr. Newcomb to study the matter further, with the understanding that the Council was not opposed to having a commercial sponsor for the program. The precedent for this is the fact that the Schenley Laboratories sponsor a program broadcast with the approval of the American Medical Association."

In accordance with this resolution the Bureau of Publicity has studied and taken preliminary steps toward obtaining a commercial sponsor for its broadcasts. This is done because better time can be obtained upon a radio station for a commercial sponsor than for a sustained program.

The bureau has sent the following letter to some thirty companies who advertise in THE JOURNAL and are exhibitors at the annual state meetings:

> "The Indiana State Medical Association wishes to call your attention to a plan to interest the public in better health care.
>
> "Beginning in October, we plan to put our daytime sustaining radio program, 'DOCTOR GOODHEALTH,' on at night. This program, which has been continuous over WFBM in Indianapolis for two years, and rebroadcast over many state stations, uses dramatized incidents, talks with an old family doctor, interviews with front-line physicians—all with information on health provided by the best men in each field. It has an established audience in the densest listening population area of the state.
>
> "It has been suggested that for a thirteen-week period we present these programs under the sponsorship of firms whose products doctors use most, with those firms interested in the project sponsoring one or more of the programs in the series.
>
> "The script would be prepared and presented by professionals, under our supervision. Time would be allotted for three commercial announcements, to be supplied by the sponsor, subject to the approval of the Bureau of Publicity of the association. Advance notice of the broadcast will be supplied to state and local medical journals and to daily newspapers.
>
> "Your company is invited to consider sponsoring the broadcast for one or more of the programs in the thirteen-week series. If you are interested, we shall be glad to confer with a representative of your company at any time."

Much interest is indicated on the part of the advertisers in such a program, and as this report goes to press the problem is being studied with the possibility of a definite arrangement being completed by the time the House of Delegates meets.

(3) *Talks to the public and medical societies:* The custom of county medical societies calling on the bureau for speakers for medical and lay meetings has been continued during the year. Due to the fact that all physicians have been so busy, and to travel difficulties, the bureau has been somewhat hesitant in filling these requests unless there is some definite assurance that the meetings will be of such a size and importance as to be worth while for the speaker to make the trip. It is most discouraging to have an out-of-town doctor attend a meeting as a guest of a county medical society and have only a few doctors turn out. However, the bureau always does its best to fill emergency engagements whenever called upon.

(4) *Speakers' kits:* When Congress convenes this fall there is a possibility that the Wagner-Murray-Dingell Bill will receive much attention, and a series of committee hearings may be anticipated. In order to be prepared to discuss this measure from a factual standpoint the bureau has assembled a speakers' kit. The material contained in this kit for the 1945 bill is in many respects similar to the material in the 1943 kit, which proved most useful when that version of the Wagner-Murray-Dingell Bill was under consideration. The 1943 kit, which was approved by the Council on Medical Service and Public Relations of the A. M. A., was used as a model by several other state societies and received national distribution.

(5) *Cooperation with committees of the state medical association:* The bureau has cooperated especially with two committees of the association during the year, in supplying speakers for county and district medical society meetings.

a. *Committee on Industrial Health:* This committee sought to have one meeting in each society during the year devoted to the problems of industrial medicine, and asked the bureau to cooperate. As a result, notices were sent out by the bureau to each county society, stating that speakers on that subject were available, with the result that many worth-while and successful meetings on this important phase of medicine were held.

b. *Committee on Mental Health:* Realizing the importance of mental health in the rehabilitation program for the returning soldier, and the importance of the subject as the result of legislation passed at the last session of the legislature in regard to mental health clinics, this committee had adopted ways and means of keeping the profession informed on this subject. Like the Committee on Industrial Health, this committee has made a group of speakers available to present this subject before county and district medical society meetings. The bureau is pleased to cooperate with this effort and has notified each county society secretary of the

fact that speakers in this specialty may be obtained.

(6) *Articles released to the press:* The following releases were issued for state-wide distribution by the Bureau of Publicity during the year:

"Tropical Diseases—Fungus Diseases."
"Tropical Diseases—Animal-borne."
"Tropical Diseases—Malaria."
Annual Session of the Indiana State Medical Association, at Indianapolis (9 releases).
Three special releases to *Indianapolis Star, News,* and *Times.*
Three special releases to Press Association, *Indianapolis Times, News, Star,* and Radio Editor.
"Secretaries' Conference."
Fourteen "Doctor Goodhealth" releases.
Special release on resolution passed by Executive Committee concerning release of doctors from armed services.
"Your Place in the Sun."
"Beware of Bugs."
"Summer Health Hazards."
"Swimming."
"Keeping Cool."

### III. Other Duties of the Bureau

The bureau desires to compliment the Woman's Auxiliary to the Indiana State Medical Association for its effective work during the past year. As advisory committee to the Woman's Auxiliary, officers and chairmen of the various individual committees of that organization often have called upon the bureau for information and advice, and the bureau has been most pleased to respond to these requests to the best of its ability. The Woman's Auxiliary has established a reputation throughout the country for the series of public meetings which were sponsored and arranged in various communities by local auxiliaries. The bureau feels that these meetings were worth while, and it is hoped that this coming year, if national health legislation becomes a matter of public interest, the Auxiliary will arrange for a new series of meetings.

### IV. Financial Statement of the Bureau

The expenditures of the Bureau of Publicity from August 1, 1944, to August 1, 1945, follows:

| | |
|---|---|
| Clippings | $ 49.46 |
| Postage | 173.91 |
| Stationery and mimeograph supplies | 129.73 |
| Printing | 6.00 |
| Salary, script writer | 1,374.51 |
| Broadcasting expense | 301.59 |
| Miscellaneous | 114.30 |
| Total expense | $2,149.50 |

H. G. Hamer, M.D., *Chairman,*
Ben B. Moore, M.D.,
Karl M. Ruddell, M.D.

## COMMITTEE ON CIVIC AND INDUSTRIAL RELATIONS

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

The Committee on Civic and Industrial Relations had no activities during the year and therefore has no report to submit.

M. C. Topping, M.D., *Chairman,*
G. H. Wisener, M.D.,
Fred B. Wishard, M.D.

## COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

The Council on Medical Service and Public Relations, of the Indiana State Medical Association, met in Indianapolis on August 5, 1945, and adopted the following resolutions:

(1) The council enthusiastically approves the fourteen-point program of the Council on Medical Service and Public Relations, of the American Medical Association, and urges that every county society devote one meeting to its discussion, and that speakers be supplied when requested.

(2) The council recommends that our delegates to the American Medical Association be instructed to present a resolution to the House of Delegates, commending the work of the Council on Medical Service and Public Relations, and that specific instructions be given that funds, personnel, and equipment necessary for the council to carry out these fourteen points be made available by the officers and the Board of Trustees of the American Medical Association.

(3) In order that this program may be carried out on a state level, this council recommends that a program of prepayment medical care be adopted by the state medical association and be put in operation as early as is feasible, and that further action as is necessary be taken by the state association through its regular and special committees to cooperate fully with the American Medical Association in putting into action the fourteen-point program.

C. A. Nafe, M.D., *Chairman*
C. H. McCaskey, M.D.
N. K. Forster, M.D.
J. E. Ferrell, M.D.
F. T. Romberger, M.D.
Norman M. Beatty, M.D.
J. William Wright, M.D.
H. G. Hamer, M.D.
W. U. Kennedy, M.D.
M. C. Topping, M.D.
W. H. Howard, M.D.
E. M. Shanklin, M.D.
Thomas A. Hendricks, *ex-officio.*

## COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

There has been no meeting of the Committee on Medical Education and Hospitals. At the request of our president, Dr. N. K. Forster, the chairman of the committee has made some investigation concerning adequate hospital facilities in the state. He was informed that the Indiana State Medical Association office had made a thorough check-up on each county, and this information is available to the president. This committee will hold a meeting at the first opportunity.

ROBERT M. MOORE, M.D., *Chairman,*
E. N. KIME, M.D.,
MERRILL S. DAVIS, M.D.,
C. J. CLARK, M.D.,
O. O. ALEXANDER, M.D.,
HERMAN BAKER, M.D.

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## THE JOURNAL

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

On next January first THE JOURNAL will begin its fourteenth year under the present setup. During this period we believe it has undergone many changes, all for the better. It is a much larger magazine, carries more reading and far more advertising pages. There were times when we could —and did—boast of the increase in the number of pages printed in successive issues; we do not do so at present because of the limitation on paper stock. Late last year we were advised by our printers that we had exceeded our quota, and that this would have to be made up in the first quarter of this year; accordingly, we set ourselves to that task, and now are again clear in that regard.

It might be of interest to go into a brief history of your magazine—many of our younger members are not familiar with this story.

Some thirty-eight years ago we had no official magazine, our records of annual meetings being published in a volume known as the *Transactions of the Indiana State Medical Society.* At a meeting of the House of Delegates an *oral* contract was entered into with the late Dr. A. E. Bulson, of Fort Wayne, then editor and publisher of the *Fort Wayne Medical Journal.* By the terms of this contract Dr. Bulson was to receive from the society the sum of seventy-five cents per member, annually. With this remuneration he was to publish a monthly magazine, without definite assistance from the society. He maintained his own organization. His annual reports to the council were perfunctory and informal, and there was no mention as to the financial phases of this venture.

Upon the death of Doctor Bulson the council was called into emergency session, and plans were made to take over the publication of THE JOURNAL. A special committee was appointed to study various plans, and finally the present setup was evolved and adopted.

At the Michigan City session, in 1932, the council formally elected the present editor and outlined the plans he was to follow. Miss Toman, now Mrs. Joseph Skobba, consented to move from Fort Wayne to Indianapolis, and for many years served as assistant editor, later being succeeded by Miss Nella Rokke, who still is with us.

It is but natural that it required several years for the new organization to operate smoothly, but this was accomplished with the help and advice of a host of medical friends throughout the state. We are frank in stating that it is our belief that we are giving you a top-notch state medical magazine, one that compares most favorably with others throughout the nation. And all this is accomplished only because we have a crack organization; because we have a most wholesome support from our members, and, finally, because we have a fairly constant supply of worth-while articles from our own members.

Reviewing the past year, we may say that our petty—sometimes not so petty—difficulties have been many. There are times when Miss Rokke, Miss Stanley, and the Blonde Boss have torn their hair in desperation. But this will not occur so frequently in 1946, for we have an addition to our headquarters' staff, Ray Smith, who has had considerable experience in the printing and publishing game, and who will be of material assistance to our JOURNAL staff.

And there is some mead of praise due our publishers; running a print shop on a large scale is quite some undertaking these days, so we are advised by the heads of many such institutions. Many factors unknown to the printers art years ago have crept into the picture, which have accounted for delays in getting our product on your desk. However, that has been the case with all state magazines.

But the quality of the product remains high; we are getting a good printing job—so good, in fact, that several other state editors have written us, asking, "How do you get this?"—referring to color work or to one of our cover pages, et cetera.

We still publish about the usual number of special issues, and hope to be able to continue this program. The outlook for scientific articles is not good just now, chiefly because of the fact that there may not be an annual session, which usually gives us quite a backlog of papers. However, by dint of writing to members throughout the state we have thus far managed to take care of the problem. With the return of many of our service members, we expect many entertaining and informative articles from them, detailing actual experiences in overseas service, combat, et cetera. We

also hope to profit from their invaluable experiences in the scientific field.

We wish to pay tribute to the immediate office staff, Miss Rokke and Miss Stanley. These young ladies have done a real job under trying circumstances. Already finding their day's program well filled, there comes this and that extra duty—a job that must be done right now, and they do it regardless of the overtime it may require. Most members know little of the mechanical task of getting material ready for the printer. Once the material is edited, type set, and proof corrected, most members think that the job is done, but that is not so. Miss Rokke then plans the whole layout, cutting and pasting each page; that is, she makes a "dummy" which when completed goes to the printer. In reality it is a complete JOURNAL, with every line and page accounted for. In addition to this there is a daily grist of correspondence which cannot be put off until another day. So a little *salvo* for the headquarters' staff.

We also take occasion to thank the membership-at-large for its cooperation, and for the many notes of commendation we receive. It *is* a job to get out a magazine at any time, and wartimes add to the many intricate problems that must be met.

We conclude with the hope that this is the end of the war, and that in 1946 THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION may continue to be bigger and better than ever.

E. M. SHANKLIN, M.D., *Editor.*

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## COMMITTEE FOR THE STUDY OF LAY ACTIVITY IN MEDICAL PRACTICE

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

**MINUTES OF A MEETING ON AUGUST 5, 1945, OF THE COMMITTEE ON LAY ACTIVITY IN MEDICAL PRACTICE**

Present: W. D. Gatch, Indianapolis, chairman; O. O. Alexander, Terre Haute; A. E. Stinson, Rochester; F. A. Streck, Lawrenceburg; F. T. Romberger, Lafayette; G. O. Larson, LaPorte.

Absent: Julia S. Thom, Spencer; M. C. Pitkin, Martinsville; Michael Shellhouse, Gary.

The committee began its work with a discussion of the complicated public relations of the medical profession. Points brought out in the discussion were:

1. That the conditions of medical practice are so vastly different in various parts of the United States that no one plan of combatting lay interference with it can be devised. Therefore, the profession of each state should adopt the principle of home rule, but, should, of course, continue to cooperate fully with the medical profession of the entire country.

2. We must prepare ourselves for the possibility that pending legislation objectionable to the medical profession may be enacted before long. The consideration that this legislation has great vote-getting power may influence many legislators to vote for it despite the cogent arguments against it presented by the medical profession. The committee believes that the passage now of legislation which will make far-reaching changes in medical practice is wrong; that its consideration should be delayed until the return to civil practice of the fifty-five thousand physicians in the armed forces. The medical profession has sacrificed more and contributed more to our successful war effort than any other group in the population. It is in a poor position at present, when nearly all its members under fifty are in the service of their country, to make its opposition to the pending legislation felt. The committee believes that the passage of legislation on medical practice which the majority of the medical profession regards as unworkable and unjust would be a public calamity, and that it would sooner or later be repealed. The committee believes that labor leaders, social workers, and other people who are demanding more and better medical care would thus learn that good medical care cannot be legislated into existence or be bought by money alone, and that the most certain way to give people poor medical care is to commercialize medical practice and to destroy medicine as a learned profession. The only possible way to give people better medical care is to give them better doctors.

3. That the best and only certain method we possess of preserving the standing of our profession is to unite our members in an effective effort to give the public good and satisfactory medical care. The general public in reality is complaining far less than our opponents claim. The dangers which confront us are, nevertheless, very great. We must solve the problems which will attend the resumption of competitive practice upon the return of our members from the war. We must provide adequate postgraduate instruction for these men and for the profession in general. We must be ready to adapt medical practice to the difficulties which pending legislation would inflict upon it. All this demands a united profession. The committee believes that every effort should be made to unite our members as they have never been united before.

The committee, in light of the foregoing considerations, made the following recommendations:

1. That the president of the Indiana State Medical Association be asked to confer with the president of the Indiana State Bar Association and the president of the Indiana State Dental Association in order to unite these three bodies against socialization of their professional activities.

2. That the president appoint a committee composed of members from various parts of Indiana to consider a plan for a new and more democratic constitution for the Indiana State Medical Association. The committee fears that many of our members feel that they have too little voice in the election of officers and in the formulation and execu-

tion of policies. The committee wishes to make it plain that this recommendation implies no criticism of any officials of the state organization, past or present. The criticism it makes is of the plan of organization, and not of the officials who head it. It believes that the present organization is antiquated and unfitted to cope with present problems which confront us. It hopes that the proposed committee may be able to present a plan of organization which will command the interest and support of every reputable physician of the state.

3. That as soon as possible THE JOURNAL of the Indiana State Medical Association publish a complete chart of the present administrative and representative setup of the Indiana State Medical Association, which will show how councilors, members of the Executive Committee, and all other officials are elected, and what duties they perform.

4. That copies of the minutes of each meeting of the State Executive Committee be sent at once to the secretaries of each county medical society, who will read them to the members.

5. That all members of the State Medical Association be informed that they have no legal right to deprive an indigent patient of his right of privileged communication by disclosing any facts they may have learned about him to any lay person whatsoever. This is the official opinion of Attorney General Emmert. The committee fears that many physicians, through ignorance, are violating this right of indigent patients, and that by so doing they are fostering the grip of various lay organizations on medical practice.

6. That every member of the State Association be urged to take pains to inform each of his own patients of the evils of socialized medical practice.

7. That all lay organizations which collect money for medical purposes be urged to seek professional advice, and that approval of campaigns of this sort be withheld unless an accurate, detailed, and public accounting of the expenditure of all funds collected be guaranteed.

8. That the president be asked to appoint a chairman and other officers for the new section on general practice, authorized by the House of Delegates at its last meeting.

9. That the State Medical Association support in every possible way the movement to make every hospital of over one hundred beds in the state a center of postgraduate training for its staff and for physicians in the community it serves. The committee believes that all plans for postgraduate instruction of physicians in active practice devised in the past have been very inadequate because they do not provide for continued study and self-education by the students. The plan in question is being sponsored right now by national medical organizations for the purpose of providing educational facilities for physicians returning from the armed forces. The committee believes that its adoption will not only accomplish this purpose, but will also raise the standards of medical practice in every community, will benefit every physician who participates in it, and will do much to retain the respect of the public for our profession.

W. D. GATCH, M.D., *Chairman,*
O. O. ALEXANDER, M.D.
JULIA S. THOM, M.D.
A. E. STINSON, M.D.
F. A. STRECK, M.D.
F. T. ROMBERGER, M.D.
M. C. PITKIN, M.D.
MICHAEL SHELLHOUSE, M.D.
G. O. LARSON, M.D.

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## COMMITTEE ON SECRETARIES' CONFERENCE

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

The Secretaries' Conference was held in Indianapolis, at the Claypool Hotel, on Sunday, January 21, 1945, with about one hundred fifty members in attendance. The general theme of the meeting was the effect of the war and the emergency situation, including threats of the government, on the medical profession.

"The Bolton Law and Its Relationship to the Patient" was discussed by Jane E. Taylor, nurse education consultant, Division of Nurse Education, United States Public Health Service, Chicago.

Mr. Don C. Hawkins, special agent of the American Health Insurance Corporation, Chicago, gave a brief outline of "Group Malpractice Insurance," and discussed the problems involved in health and sickness insurance.

"The Children's Bureau Program" was presented by Dr. John D. Van Nuys, medical director of the Indiana University Medical Center, Indianapolis.

Dr. Charles Fidler, president of the State Medical Society of Wisconsin, Milwaukee, discussed his interviews with Senator Wagner, Mayor LaGuardia, Miss Lenroot of the Children's Bureau, the Department of Labor, the Surgeon General of the United States Public Health Service, and others. He said that the attitude of most of these individuals, the Surgeon General of the Public Health Service excepted, was that of telling the medical profession what they were planning on doing, rather than asking for advice and cooperation of the profession in working out problems of public health and care of the sick.

Dr. Norman Beatty and Dr. J. William Wright, Indianapolis, co-chairmen of the Legislative Committee, discussed legislative problems, while Dr. O. E. Wilson, secretary of the Elkhart County Medical Society, gave a paper summarizing the answers to a questionnaire concerning the activities of the county medical societies of the State of Indiana. He stressed a strong public relations effort on the part of county societies.

Dr. N. K. Forster, Hammond, president of the state association, presided at the dinner meeting, at which time Governor Ralph F. Gates addressed the doctors. The principal speaker of the evening

was Congressman Arthur L. Miller, of Nebraska, who spoke on "Uncle Sam Practices Medicine." Since Congressman Miller is a physician, he warned the profession in his talk to concentrate on something definite, if it wishes to prevent federal control of the profession.

Dr. A. M. Mitchell, Terre Haute, was elected chairman of the conference for 1945.

A. M. Mitchell, M.D., *Chairman*,
W. M. Dugan, M.D.,
W. G. Pippenger, M.D.,
O. E. Wilson, M.D.,
O. A. Turner, M.D.

## COMMITTEE ON REHABILITATION SERVICES

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

The Committee on Rehabilitation Services is working out the various phases of the subject in preparation for a meeting.

John Hewitt, M.D., *Chairman*,
Bert E. Ellis, M.D.
Ray Elledge, M.D.
Myron S. Harding, M.D.
Robert B. Acker, M.D.
E. Vernon Hahn, M.D.
Keith T. Meyer, M.D.
Frank M. Gastineau, M.D.
N. H. Prentiss, M.D.
James O. Ritchey, M.D.
James F. Balch, M.D.
Harold M. Trusler, M.D.
George A. Collett, M.D.

## COMMITTEE ON PREPAYMENT OF MEDICAL AND SURGICAL CARE

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

The final report of this committee is to be made at a special session of the House of Delegates, and is not yet finished. Throughout the year subcommittees have been making intensive studies of the three principal types of insurance.

Investigative visits have been made to many cities, conferences have been held with similar committees of the surrounding states, and informative material has been secured by correspondence nation-wide. Views of national political leaders have been obtained, pointing clearly to the urgent need of the adoption by this association of some plan to help forestall adoption by the Federal Government of an all-embracing system of medical care insurance which would be catastrophic for the profession. We are assured of powerful support politically provided we supply a platform of action from which defense may be based. It is useless to expect even our strongest friends to fight for us if we do nothing but utter loud protests. The national economic trends indicate clearly that if we do nothing to spread the costs of medical care the government will do it for us.

W. U. Kennedy, M.D., *Chairman*,
G. M. Nie, M.D.,
Justin R. Nash, M.D.,
F. R. N. Carter, M.D.,
Robert Masters, M.D.,
Lyman T. Meiks, M.D.,
F. S. Crockett, M.D.,
W. H. Howard, M.D.,
A. J. Sparks, M.D.,
W. L. Portteus, M.D.,
A. P. Hauss, M.D.,
Robert Acre, M.D.,
C. Philip Fox, M.D.,
Claude Dollens, M.D.,
I. M. Sanders, M.D.,
M. C. Topping, M.D.,
Joseph L. Allen, M.D.,
Marlow W. Manion, M.D.,
Bruce Stocking, M.D.,
Wemple Dodds, M.D.,
J. Robert Doty, M.D.

## COMMITTEE ON NECROLOGY AND HISTORY

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

The report on necrology is published annually in the earliest possible number of The Journal.

So far as work on a Medical History is concerned, considerable progress has been made in collecting material and writing up the story of several sections of the state. In addition, it is hoped that by combining the effort of this committee and the Centennial Celebration Committee a memorial volume can be published in celebration of our centennial year.

James B. Maple, M.D., *Chairman*,
W. D. Inlow, M.D.,
L. G. Zerfas, M.D.,
E. R. Clarke, M.D.,
L. W. Vore, M.D.,
George S. Row, M.D.,
P. J. Birmingham, M.D.

## COMMITTEE ON MENTAL HEALTH

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

Your Committee on Mental Health has not been in a position to hold more than one regular meeting this past year, at which time psychiatric problems

of the returning war veteran were discussed at length. Just at present this committee is working out a plan whereby the services of speakers, under the direction of your Publicity Bureau, will be available to discuss these problems before industrial groups, luncheon clubs, employment agencies, et cetera. There is a constant demand for speakers of this sort, and we believe that it should be under the supervision of the state medical society.

This past year has been one of unusual activity from the standpoint of mental health in this state. The public generally and legislators particularly have become aware of the many deficiencies in our system of commitment and management of the mentally unfit, and as a result *Senate Bill No. 206* was passed by the last legislature. This bill provides for a State Council on Mental Health. This council has wide jurisdiction over all state and private psychiatric hospitals, and is authorized to build and operate a state psychiatric hospital in association with the Indiana University School of Medicine. Already a tentative site has been selected and certain funds are available for beginning construction. This bill, we believe, is the greatest move ever made to systematize and coordinate the management and care of the psychiatrically ill. We further realize that under present conditions we will meet many obstacles and that progress necessarily will be slow.

Again your committee wishes to express congratulations to the members of this group who are in the military service. They are all doing wonderful work and are distinguishing themselves in military medicine.

L. D. Carter, M.D., *Chairman*,
L. P. Harshman, M.D.,
C. L. Williams, M.D.,
P. B. Reed, M.D.,
G. E. Metcalfe, M.D.,
Max Bahr, M.D.,
P. S. Johnson, M.D.

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## COMMITTEE ON PHYSICAL FITNESS

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

The Committee on Physical Fitness had no meetings during the year, and therefore has no report to make.

W. C. Moore, M.D., *Chairman*,
W. C. Kunkler, M.D.,
George S. Bond, M.D.,
G. A. Thomas, M.D.,
H. C. Wadsworth, M.D.,
James H. Crowder, M.D.,
C. R. Herd, M.D.,
W. A. Thompson, M.D.,
W. D. Little, M.D.

## ADVISORY COMMITTEE TO THE BUREAU OF MATERNAL AND CHILD HEALTH OF THE INDIANA STATE BOARD OF HEALTH

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

**Minutes of the Meeting, June 20, 1945**

Present at the meeting:

G. L. Verplank, M.D., *Chairman*
Mahlon F. Miller, M.D.
Foster J. Hudson, M.D.
R. A. Craig, M.D.
G. W. Gustafson, M.D.
H. W. Eggers, M.D.
Frank C. Walker, M.D.
R. E. Jewett, M.D.
Leroy Burney, M.D.

I. After the reading of the minutes of the last meeting, Dr. Jewett, director of the Division of Maternal and Child Health, outlined the history of the development of maternal and child-health programs and their public health aspects. The importance of a maternal and child-health program as part of general public health activities was explained.

II. The maternal and child-health program as developed in the State of Indiana was discussed, and various aspects of the program were outlined, such as public health nursing services, nutrition services, dental health services, the premature care program, inspection and licensure of maternity homes and hospitals, and public and professional educational programs. It was brought out that no new projects were planned for the fiscal year beginning July 1, 1945, and it was reported that many of the maternal and child-health services had been curtailed due to the loss of personnel during the war emergency. Although the Child-Health Conferences in rural areas of the state were for the most part continuing, the maternity nursing services in certain counties of the state were discontinued due to the loss of specialized maternity nurses. Counties in which maternity nursing services were discontinued were Allen County, Spencer County, Perry County, Monroe County, Floyd County, Ohio County, and Switzerland County. It was explained that the maternal and child-health programs given greatest emphasis in normal times had suffered because of the necessity of concentrating the efforts of the personnel of the Division to the Emergency Maternity and Infant Care Program for the wives and infants of men in the armed forces.

III. Dr. Burney discussed the status of the Murray-Wagner-Dingell Bill in Congress, and expressed the opinion that it was the consensus of most interested parties that the bill had very little likelihood of passing at this time.

IV. Dr. Jewett made a report on the administration of the EMIC Program for soldiers' families,

and reported that approximately 25,000 cases had been authorized since the beginning of the program in June, 1943. During the calendar year ending December 30, 1944, 9,897 maternity cases were completed for payment at an average cost of $93.80. During this same period 1,093 pediatric cases had been closed, and payment made at an average cost of $38.75. Both maternity and pediatric cases included medical, nursing, hospital, and other care.

V. The committee took up the plans for the administration of both the maternal and child-health and the EMIC programs for the fiscal year beginning July 1, 1945. By consent it was agreed that no new programs could be developed in the maternal and child-health program for the new year. The new program for the inspection and licensure of all general and specialized hospitals, for which the Indiana State Board of Health was made responsible by an Act of the last session of the Indiana General Assembly, was discussed, but it was agreed that no action or plans could be made at this time since the newly-appointed Advisory Committee on Hospital Licensure had not yet met. Dr. Jewett explained that the dental health services would no longer be an activity of the Division of Maternal and Child Health since a Division of Dental Health was being developed as a new activity of the Indiana State Board of Health.

VI. The complete plan of administration for the EMIC Program for the next fiscal year was covered in detail, and every aspect of the policies and fees were analyzed and passed upon. With few exceptions and certain expressions of criticism of the policies as dictated by the United States Children's Bureau, it was agreed that the plan of administration would remain very much the same as that which prevailed during the fiscal year ending June 30, 1945. The exceptions and the decisions of the committee are as follows: The matter of eligibility of persons applying for care under the EMIC Program was discussed at length, and it was the decision of the committee that application for pediatric care of an expected child might be made at the same time that the application for maternity care of the mother was filed. It was the decision of the committee also that application for maternity care might be made after a change of status of the man in the armed forces, such as promotion to an ineligible pay grade or discharge from service, if conception took place prior to the change of status. It was the decision of the committee that this method of establishing eligibility after a change of status or discharge from service was more logical than designating the end of the EMIC Program as that point in time defined as "duration and six months thereafter." The labor unions are advocating in Congress that the eligibility be extended for two years after discharge of a man from service. It has been thought that the above-mentioned method of establishing eligibility was a fair and safe compromise. Dr. Jewett reported to the committee that due to the curtailment of the peacetime MCH program, there was a considerable balance in the regular MCH funds allotted to Indiana. The committee discussed the matter of using these funds to extend the services provided under the EMIC Program, to take care of certain unusual cases not eligible for assistance under the act providing for the EMIC services. The committee discussed and passed upon the following exceptional services to be provided for from the MCH unexpended balances: (1) Medical and hospital care of children over one year of age: It was agreed that the Director of the Division of Maternal and Child Health might use administrative judgment in authorizing care for children over one year of age when the conditions and circumstances seem to warrant it, and when the child's father is in the service and in one of the four eligible pay grades. (2) Care for Unmarried Mothers: It was agreed that the Director of the Division of Maternal and Child Health might use administrative judgment in authorizing care for unmarried mothers when there was tangible evidence that the father of the child was an eligible serviceman. (3) Maternity care for enlisted women in the armed service: Since the wording of the act providing for the EMIC Program excludes maternity care for women in the armed forces in the four lowest pay grades, the committee agreed that care might be authorized for this group. (4) Care for the wives and infants of men in the first, second, and third pay grades: Since the families of non-commissioned officers in the first, second, and third pay grades are not eligible under the EMIC Program, and since a serious need for assistance sometimes occurs in this group, it was agreed that the Director of the Division of Maternal and Child Health might use administrative judgment in authorizing care for persons in this group when there was clear evidence of a serious need for assistance. It was moved by Dr. Gustafson, seconded by Dr. Hudson, that these exceptions be adopted, and motion was passed by the committee. The committee reviewed the fee schedule established for the fiscal year ending June 30, 1945, in detail, and agreed to adopt it as it stands for the next fiscal year. It was reported to the committee that the Children's Bureau might in the near future adopt a plan giving the state the option of setting up a single flat fee of fifty dollars for maternity care without any prorating for the extent of prenatal, delivery, and postpartum care involved. The committee agreed that if such an option was granted the flat fee should be adopted. It was reported to the committee that new directives from the Children's Bureau would permit the establishment of some method of making adjustments for unusual care in serious or complicated cases, and such cases could be reviewed and passed upon by an Advisory Committee of the Indiana State Medical Association. The committee agreed to adopt the following plan of review and making adjustments: reports of medical services indicating serious illness or complications, requiring unusual care and many visits, would be set aside and accumulated for thirty days

to be submitted to the Advisory Committee for review. The present Advisory Committee will serve as the committee to review for adjustments, and a quorum of the committee composed of not less than three members will meet once a month to review these cases, and to decide upon adjustment. It was agreed that the maximum adjustment should not exceed four times the maximum fee payable under the original authorization.

The matter of routine or well-child care during the first year of life was discussed by the committee. It was pointed out that the Children's Bureau policy would permit the establishment of a maximum fee of sixteen dollars for the first year of life, when the services included well-child care, care of sick infants, and immunizations. The committee agreed that this was an entirely inadequate method of payment, that the Division of Maternal and Child Health should not adopt this policy, and should not, therefore, authorize well-child care.

After review of the entire plan, the policies, and fees, with the above-mentioned exceptions, the plan was approved and adopted by the committee.

It was moved by Dr. Eggers, seconded by Dr. Craig, and passed by the committee, that although it must accept the dictated policies of the United States Children's Bureau, under present circumstances and conditions, the committee should go on record as expressing its disapproval of certain aspects of the policies. The points of disapproval of the federal EMIC program were as follows: (1) The effective date of authorization: It was resolved that the policy of permitting the physician and patient to request the effective date of authorization late in pregnancy, permitting the patient to pay for care received prior to that time, was not in keeping with the spirit and intent of the program, and that the matter should be brought to the attention of the Executive Committee. (2) The all-or-none policy stipulating that the patient might not pay for any part of either the authorized medical, nursing, or hospital care upon penalty of cancellation of all authorizations: It was resolved that the committee should go on record as disapproving of the interpretation of the Act of Congress which stipulates that applicants might not choose to apply for medical care alone, or hospital care alone, and arrange, as a personal responsibility, to pay for one or the other of the services received. The committee also resolved that it wished to be on record as believing that a spot-cash indemnity payment to the applicant, rather than a fee for service payment to physicians, would be a method of choice, although the wording of the present act providing for the appropriation does not allow this. The committee wishes to make itself clear that it gives approval of and willingness to cooperate with the EMIC program only as an emergency measure, as the term implies, with the definite understanding that this program shall terminate at the earliest possible date after cessation of hostilities.

As a final action, it was agreed by the committee that the next meeting would be called by the chairman of the committee upon the suggestion of the Director of the Division of Maternal and Child Health.

G. L. Verplank, M.D., *Chairman*,
Mahlon F. Miller, M.D.,
Foster J. Hudson, M.D.,
R. A. Craig, M.D.,
G. W. Gustafson, M.D.,
Milo K. Miller, M.D.,
Louis H. Segar, M.D.,
H. W. Eggers, M.D.,
Frank C. Walker, M.D.,
O. T. Brazelton, M.D.,
I. C. Barclay, M.D.,

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## LIAISON COMMITTEE OF THE DIVISION OF SERVICES FOR CRIPPLED CHILDREN

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

The Liaison Committee of the Division of Services for Crippled Children held no meeting during the year, and therefore has no report to make at this time.

Gordon W. Batman, M.D., *Chairman*
H. E. English, M.D.,
C. O. Almquist, M.D.,
George J. Garceau, M.D.,
Charles E. Woodcock, M.D.,
George Cook, M.D.,
G. H. Kamman, M.D.

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## AUDITING COMMITTEE

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

The Auditing Committee met at the Indiana National Bank on August 1, 1945.

The investments of the Association, as listed by George S. Olive and Company, certified public accountants, in the treasurer's annual report (see page 333), were examined and found to be in order in both the General Fund and the Medical Defense Fund, and The Journal Fund.

Cash balances in The Indiana National Bank, The American National Bank, The Fletcher Trust Company, and The Bankers Trust Company, as shown by the bank statements, also were examined. These accounts consist of the General Headquarters' Office Fund, the Medical Defense Fund, The Journal Fund, and the Petty Cash Fund, respectively.

O. B. Norman, M.D., *Chairman*,
Charles Wise, M.D.,
R. H. Elliott, M.D.

## COMMITTEE ON CONTROL OF CANCER

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

Your committee begs to report a busy year. The members have worked cordially with The Field Army and other groups interested in cancer control. Five years ago we undertook a campaign whose chief purpose was to educate the public concerning cancer. This effort was eminently successful, and I feel quite safe in saying that the public in Indiana is thoroughly cancer-conscious. This portion of our campaign continues and will continue, but within the last year we have aligned with The Field Army of the American Cancer Society, undertaking a number of projects which in addition to the educational features are intended to deal more with research and treatment of cancer. Due largely to the efforts of Dr. C. A. Stayton, of our committee, these projects have been more or less well organized and work in this direction continues. Among our projects are:

I. Establishment of Detection Clinics:
   A. Indianapolis—
      a. Indianapolis City Hospital.
      b. Indiana University Hospitals.
   B. Anderson.
   C. Lafayette.
   D. Rensselaer.

There is an effort to have these clinics largely a matter of detection, and they are open to all for diagnosis. Treatment in these clinics is limited to those unable to pay. These detection clinics are insofar as possible staffed by a clinician and a laboratory man.

II. Establishment of a Fellowship at Indiana University for Research in Cancer:

This fellowship, which is to be an annual affair, is to be financed by The Field Army. While The Field Army has been our greatest helper in these projects, they are by no means alone. In fact, the most gratifying aspect of this effort is the change in attitude of the doctors who do this work. They are enthusiastic and hopeful; more of them are talking to clubs and other organizations on the subject of cancer and are pleased with their reception.

Along this same line it is a pleasure to report that the fight to control cancer has received the attention of the Lions Club. As this is a national organization of no mean influence we look forward with a great deal of confidence to the good they will accomplish, since they are enthusiastic, have the means at their disposal, and are an organization of men whose voices will be heard in behalf of the cancer sufferer.

Also there has been appointed, by The Field Army, Miss Milicent Duckworth, whose duties consist of follow-up work on patients who have been examined and diagnosed, and in some cases treated. Her duties are largely a matter of contact, history-taking, and record-keeping. At present she handles cases in state and city hospitals.

Another item of direct interest and practicability is the so-called "cancer cupboard." This idea also had its inception in the present year. It is part of The Field Army and furnishes dressings, medicines, bandages, drugs, et cetera, for the benefit of the incurable indigent cancer sufferer on a basis of lending instead of selling.

All in all this has been a busy and profitable year to the members of your committee, and we hope helpful to the public in general and the cancer patient in particular. We are all looking forward to some move by which we may establish, or have established, a hospital under the supervision of the medical profession for the treatment and relief of the incurable cancer patient.

E. E. Padgett, M.D., *Chairman,*
C. A. Stayton, M.D.,
Don D. Bowers, M.D.,
C. O. McCormick, M.D.,
Henry O. Mertz, M.D.,
A. S. Giordano, M.D.,
Harry P. Ross, M.D.,
E. M. Van Buskirk, M.D.,
J. J. Connelly, M.D.

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## COMMITTEE ON VENEREAL DISEASE

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

A meeting of the Committee on Venereal Disease was held in the office of the Indiana State Medical Association on May 16, 1945.

It was called to the attention of the group by the chairman of the committee that certain industrial groups throughout the state desired to create legislation for the betterment of venereal disease control. It was pointed out that some factories required pre-employment examinations and other examinations during the period of actual employment. One part of this examination was a serological test for syphilis. Where these tests proved to be serologically positive the factory management required that the patient be treated weekly by a local physician, and a statement rendered by the local physician that the treatments had been given.

The union desiring to aid the management in its effort to handle these positive serological cases passed a rule that where a person was under treatment, if he missed treatment more than two times per year he would lose his seniority in the list of employed personnel. The union stated that they felt this was a constructive program and wished to sponsor its enactment into legislation.

A great deal of discussion resulted from this proposal. The following conclusions were made:

1. That the factory management employed a physician to do these examinations either directly or under his direction and direct responsibility. The fact that he was a physician presupposes that he was properly licensed by the state.

2. That a legally-licensed physician must respect the laws of privileged communication. This being

the case, he had no legal right to divulge information to the union concerning positive serological tests without the patients' consent.

3. That the factory doctor could insist that treatment must be taken as a condition upon which employment was granted.

4. That syphilis was a contagious and infectious disease and required to be reported to the Board of Health.

5. That the factory physician who did the examination, when he found a positive serology, was required by law to report these cases to the Health Department.

6. That infectious cases of syphilis could be quarantined if they refused to take treatment. It is not anticipated that this procedure would be necessary in a very great number of cases.

7. That the attitude of the union was to be commended. There is no doubt that their motive in suggesting that legislation be created to help control venereal disease was and is very wholesome. The committee felt that already such legislation was in force in the State of Indiana. The committee felt that this matter should be explained to the unions throughout the state.

For that purpose it was suggested that an educational program be conducted by the Indiana State Board of Health. Information was to be forwarded to both management and the C.I.O. and A.F.O.L. councils. The effect of information of this type will be to acquaint both management and labor with existing legal facilities already in force. It is logical to think that this information will serve as the basis for educational procedure in both organizations.

The following motion was presented to the committee, after Dr. Bowman had asked for an expression from the members present regarding the distribution of penicillin by the State Board of Health for the treatment of venereal disease:

> Inasmuch as the status of the effectiveness of penicillin in the treatment of lues is still in the experimental state at the present time, it was moved that the Indiana State Board of Health be advised that this committee does not advise the free distribution of penicillin to clinics and physicians at present, but rather that the drug be procured for indigent cases from local funds as provided for by Indiana law.

This motion was passed without a dissenting voice.

The committee also passed a motion reiterating the former stand taken some years ago.

No industry shall be considered indigent, and serology for syphilis as a part of the pre-employment examination should not be sent to the Indiana State Board of Health Laboratory for free service.

Passed by unanimous vote.

F. R. N. Carter, M.D., *Chairman*,
C. E. Canaday, M.D.,
W. W. Hewins, M.D.,
W. P. Morton, M.D.,
E. O. Nay, M.D.,
Robert G. Moore, M.D.,
Minor Miller, M.D.,
J. S. Reynolds, M.D.,
Ernest Rupel, M.D.,
T. R. Hayes, M.D.

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## COMMITTEE ON INDUSTRIAL HEALTH

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

The Committee on Industrial Health submits the following report of its activities for the past year:

This committee, as part of its planned long-term program, has stressed continually the importance of acquainting Indiana physicians with current problems in industrial medicine. To accomplish this numerous techniques were used. In the past the committee sponsored an intensive two-day postgraduate program; however, this year, due to travel restrictions, such activities were curtailed. In lieu of this type of program the committee advocated that each district or county medical society should devote one of its regular meetings to industrial medicine. Thus far seven counties have had this type of program, and all report excellent meetings. It is our belief that after the war the postgraduate program should be continued.

Out of this endeavor arose a new type of medical meeting. For example, the Tenth District, of Lake County, had Colonel Don Hilldrup, Colonel Hall, and Colonel O. W. Sicks, of the Gardiner General Hospital, of Chicago, present a clinical type of meeting, while the Grant County Medical Society actually had its industrial medical meeting in the Owens-Illinois Glass Company plant. Thus was born an "in-plant medical meeting."

To aid in the decentralization of the educational program, speakers will be made available to the county societies if they desire this type of help.

To further develop our educational program, a special issue of The Journal is to be devoted entirely to industrial medicine. This will make the fourth such issue of The Journal.

Various members of the committee participated in the American Medical Association's Council on Industrial Health, Regional Industrial Health Conference. This was held in Chicago on June 8, 1945. Our decentralized educational, rehabilitation, and medical-ethics program was fully discussed.

After reviewing the state society's Constitution and By-Laws, we have found nothing that simulates the code of fair practice as proposed by the Industrial Health Committee. Therefore, we again submit it to the House of Delegates and members of the state society, and recommend its adoption.

"RELATIONSHIPS BETWEEN INDUSTRIAL AND PRIVATE PHYSICIANS

"It is appreciated that no laws, rules, or regulations can be made that will apply to all equally. No rules can displace common sense and good judgment. In order that we may more nearly approach the golden rule

in the relation between industry, labor, and the medical profession, the following principles are submitted:

"1. Pre-employment examinations: It is recognized that the physical examination of applicants for work is the prerogative of an employer; that the time and place of such examinations are matters within his jurisdiction; and that he must have free choice of the physician who is to make the examinations. The foregoing assumes that the employer pays the entire cost of the medical service rendered. The examining physician in this circumstance is performing a service for the employer, and has primarily the single obligation to further the employer's interest. It is recommended, however, that in the broader interest of the community he accept the following rules of practice:

a. Make available to the personal physician of an examinee a full report of the latter's examination; this to hold only in the event an examinee requests that a report be made.

b. Willingly consult with the examinee's personal physician when differences in opinion regarding medical findings exist.

c. Refrain from naming a practitioner to whom the examinee should report for correction of defects discovered in the examination.

"2. Occupational diseases and injuries: The treatment of occupational injuries and diseases is the direct concern of an employer, and the facilities and physicians provided by him for that purpose must remain within his discretion. The employer is best served in these instances by physicians and surgeons who observe the general rules of ethics of their profession. Specifically, the following points of conduct are considered important:

a. It is not ethical for an industrial surgeon, while caring for an industrial injury or disease case, to urge the patient to have a concomitant and coincidental disease treated by himself at the worker's expense.

b. Once a case of questionable liability to the employer is diagnosed as being of non-occupational origin, the patient is to be referred to his personal physician for further care.

c. In general, a physician or surgeon is not to use his industrial affiliation as a direct means of gaining a private practice among plant workers. Emphasis is placed here on solicitation, low fee arrangements, and insinuation of reprisals against those workers who insist on care by physicians of their own choice.

"Companion obligations rest with non-industrial physicians and surgeons in these matters:

a. When a private physician suspects the diagnosis of an occupational disease or injury in a patient, he should, with his patient's permission, communicate the information to the proper plant doctor.

b. When differences of opinion exist as to the compensability of medical and surgical conditions, the private physician, with the permission of his patient, is to confer with the plant doctor.

c. Statements to workers that occupational diseases or injuries were not properly treated accomplish nothing constructive, and in any case the expression of such opinions is to be withheld until there has been consultation with the plant physician for the purpose of ascertaining all pertinent facts.

"3. Health Supervisory Programs:

"Health Supervisory Programs may be properly carried on by an employer's medical personnel, if the purpose of the program be any or all of the following:

a. To discover cases of occupational disease among employes exposed to known health hazards.

b. To diagnose all possible illnesses which may influence adversely the earning capacity of workers or plant safety.

c. To determine if workers returning from sickness absenses have recovered sufficiently to carry on their jobs without injury to themselves or endangering the safety of others.

"With respect to such programs the society considers certain ethical principles to be basic. They are:

a. The results of clinical examinations must be made available to the personal physicians of the examined employes.

b. No influence is to be brought to bear on employes in their selection of personal physicians for the correction of physical defects.

c. No treatment for non-occupational diseases or injuries to be offered at the company's medical department, except in minor cases when enough treatment may be furnished a worker to make it possible for him to complete a turn of work with a minimum of injury and discomfort to himself.

d. It is recognized that the plant physician is best qualified to judge a worker's ability to return to his particular job after an illness. In the interests of harmony in the medical community, however, when there is conflict of opinion in such cases between the worker's personal physician and the plant physician, the latter shall, at the request of the personal physician, consult with him on the case.

"4. We recommend that all industries have doctors of their own choice, who are to act in the capacities of consultants or as attendants at plant medical departments.

"We believe records of the physical status of all employes are valuable as protection for both employer and employee.

"5. It is against the policy of the medical profession to have any free medical examinations in any industry for whatever purpose, unless having been first submitted to and passed by the council of the local medical society.

"We do believe in, and encourage, research work that may bring knowledge to the medical profession and benefit to mankind, but severely condemn the abuse of research as a guise for commercial purposes.

"6. Medical Testimony before the State Industrial Board:

"Any member of the society who has submitted expert medical testimony at a hearing before the State Industrial Board, in a suit for compensation, may petition the Council to review all of the medical testimony submitted at that hearing. The petition must be made after a final decision in the case has been reached. The council will have discretionary power in the matter of deciding whether or not to review the case. Once the decision has been made to review, the Council will make a reasonable effort to arrange a convenient time and place for the review. All of the physicians who submitted testimony at the hearing in question will be apprised of that time and place, and must be permitted to attend the review. The society has the duty to censure any of its members for apparently flagrant deviations from the society's standards of competency and honesty, as revealed in such a review."

The Waiver Law was repealed at the last session of the legislature. The viciousness and unfairness of the repeal has been demonstrated repeatedly, and will be most unfair to the returning handicapped servicemen. Therefore, the committee has been working with the Manufacturers Association and the Chamber of Commerce, as well as some members of labor, to have a fair and just waiver law presented to the next legislative assembly.

We wish to thank the state officers and the executive committee for their splendid support and assistance to the committee.

I want to personally thank every member of the committee for their fine work, time, and counsel, which was excellent.

As secretary of the Committee on Industrial Health, Dr. Louis W. Spolyar has been of invalu-

able service. Without him the work would have been difficult, but with him it was indeed a pleasure.

E. S. Jones, M.D., *Chairman*,
H. M. Trusler, M.D.
John Hilbert, M.D.
L. W. Spolyar, M.D.
W. R. Glock, M.D.
E. B. Mumford, M.D.
David R. Johns, M.D.
C. M. Jones, M.D.
Charles A. Weller, M.D.
Thomas Dobbins, M.D.
E. T. Stahl, M.D.
F. M. Whisler, M.D.
M. R. Davis, M.D.
C. W. Yarrington, M.D.
E. H. Carleton, M.D.

## COMMITTEE ON INDIANA INTER-PROFESSIONAL HEALTH COUNCIL

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

The council held one meeting, February 8, 1945, under the chairmanship of Dean Glenn L. Jenkins, of Purdue University. The meeting was called during the session of the state legislature for the purpose of discussing the proposed legislation of interest to the component members. The legislative calendar was especially rich with proposed beneficial legislation, those affecting the State Board of Health being among the more important. Opposing opinions among the affected health groups were harmonized with a decision to recommend active support.

Under the virile leadership of Dean Glenn L. Jenkins, the Health Council has taken on renewed activity and has served as a valuable clearinghouse and medium for possible cooperation. The council now includes the state associations of medicine, dentists, pharmacists, nurses, hospitals and veterinarians, together with representatives of the respective university professional schools and the State Board of Health.

F. S. Crockett, M.D., *Chairman*,
A. M. Mitchell, M.D.,
N. K. Forster, M.D.,
F. T. Romberger, M.D.,
Norman M. Beatty, M.D.,
J. W. Wright, M.D.

## ANTI-TUBERCULOSIS COMMITTEE

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

The Anti-Tuberculosis Committee of the Indiana State Medical Association met Sunday, July 15, 1945, at the Columbia Club, in Indianapolis. Those present were: Drs. P. H. Becker, Crown Point; J. H. Stygall, Indianapolis; H. W. Garton, Fort Wayne; and H. C. Ochsner, Indianapolis; also Holland Thompson, of the Indiana State Board of Health, and Murray Auerbach, Indianapolis.

The meeting was called to order, and the tuberculosis program in general was discussed. It was the opinion of the committee that the photoroentgen surveys that had been conducted throughout the state have proved their value, and the broadening of this method of case-finding should be sponsored and expanded by the state and county medical association. The committee suggested that these surveys be paid for by industry and individuals wherever possible, but it was also the committee's opinion that there would have to be some work conducted at the expense of the individual counties, among the school children and indigent patients. To date no survey has been conducted without the approval of the medical societies, and it is the committee's opinion that this plan be followed in the future.

The committee felt that Mr. Auerbach should be commended for the manner in which the State Tuberculosis Association has cooperated with the medical society, and that the Indiana State Medical Association should be commended for the manner in which it has handled this difficult problem.

P. H. Becker, M.D., *Chairman*,
J. H. Stygall, M.D.,
L. C. Marshall, M.D.,
H. W. Garton, M.D.,
C. W. Rauschenbach, M.D.,
H. C. Ochsner, M.D.,
J. V. Pace, M.D.

## CENTENNIAL CELEBRATION COMMITTEE

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

It was the judgment of the chairman of this committee that a meeting of the full membership this summer was an unnecessary expenditure of time, effort, and money, and a majority concurred in the decision. However, two conferences were held with one Indianapolis member to outline a letter sent to all the members, asking for criticisms or additional suggestions. The answers to this letter indicated an agreement in having an exhibit of historical items at our centennial celebration, a pageant reproducing the 1849 meeting, a radio broadcast dramatizing or re-enacting the first one-hundred years, and a guest speaker for the banquet who will inform and entertain us with the story of Hoosier Medicine.

These ideas can be elaborated as time goes on, but one project must receive our immediate attention. We would like the House of Delegates to sanction the writing of a Memorial Volume, covering the century just past. There are members of this association now living who could in the next

year or so contribute chapters on the progress of the association itself, the rise and fall of medical schools, medical journalism, the development of hospitals, the State Board of Health, the fight for protective licensure, doctors in the different wars, and other topics that readily come to mind. We will make no commitments as to finances or authorship until this report has been adopted, and a meeting of the committee has been held, but we feel that yet this year assignments should be made to start collecting manuscripts for such a book.

The one-hundredth birthday of two of our neighboring states will occur close to ours—Ohio in 1846, and Illinois in 1850—and we expect to glean some ideas from their plans. Your committee did not expect to arouse intense enthusiasm concerning an event four years hence, but we at least wanted to lay the foundation upon which future committees could build the eventual celebration.

CHARLES N. COMBS, M.D., *Chairman,*
E. F. KISER, M.D.,
L. G. ZERFAS, M.D.,
W. N. WISHARD, M.D.,
J. R. NEWCOMB, M.D.,
MINOR MILLER, M.D.,
D. A. BICKEL, M.D.,
O. B. NESBIT, M.D.,
V. L. TURLEY, M.D.,
G. IRENE POLHEMUS, M.D.,
J. B. MAPLE, M.D.,
JOHN IDDINGS, M.D.

## COMMITTEE ON CONSERVATION OF VISION

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

The Committee on Conservation of Vision held a meeting in March of 1945, at which time Drs. Allen, Rutherford, and Cassady were present. The other two members of the committee, Drs. Bulson and Erehart, were unable to attend. Plans were made at that time for the Conservation of Vision Number of THE JOURNAL of the Indiana State Medical Association. Plans were also made for assisting the Department of Public Welfare with the July issue of their magazine, which was devoted to the Conservation of Vision. Because of the difficulty of travel no other meetings were held and no other plans were made for meetings this year. It is hoped that when travel restrictions are again lifted and the war is ended a state lay organization devoted to the conservation of vision and the prevention of blindness can be sponsored in Indiana, as it is felt by the committee that such an organization is needed to effectively carry out a program for Indiana.

J. V. CASSADY, M.D., *Chairman,*
O. T. ALLEN, M.D.,
M. G. EREHART, M.D.,
E. L. BULSON, M.D.,
C. W. RUTHERFORD, M.D.

## COMMITTEE ON HARD OF HEARING

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

An attempt was made by this committee to study the causes for deafness at the Indiana State School for the Deaf. At the suggestion of the superintendent, J. A. Raney, the first-year students and parents were interviewed in January as the students returned for the second half of the year. At this time the children were not new, and the parents were highly pleased with their child's progress so that fairly good cooperation was obtained. It soon became apparent that the stated cause for deafness was often misleading. So frequently the stated cause was only contributory to an underlying condition which never appeared on the records. Since these records are what go to make up statistics, it would seem that we need more aid from experienced doctors in making out the applications to the School for the Deaf. This is particularly true since we are in a period of transition, and the statistics will soon show the effects of sulfonamides.

The possibility of helping the hard of hearing is a very pertinent topic which well deserves consideration. The majority of physicians have difficulty in determining what advice is wise in reference to hearing aids. They are not much more at sea than the otologist. It is at the suggestion of President Forster that these remarks appear in the committee report.

Any hearing aid manufacturer is capable of making a tailor-made aid for most handicapped ears. However, the time and expense required makes it impossible at present. Each manufacturer presents an aid which amplifies the speech-range tones a certain amount. No two of the aids are exactly alike in this respect. This constitutes mass production in order to keep the expense down. True, there are controls which allow greater or lesser amplification, but the relationship of intensities remain fairly constant. The A.M.A. Council on Physical Medicine tried to establish a standard audiogram for those aids which were council-accepted. The aids were changed and improved so fast that before a report could be prepared it was outdated. That leaves us with the same trial-and-error method which has been in use in the past. Each patient with impaired hearing is compelled to try out different machines until he finds the one best suited for his need.

With conditions as they are at present, the best help we could offer the patient with impaired hearing would be to institute centers where the patient might try different sets. This center must be impartial and unbiased but sufficiently interested so that the patient gets an opportunity to try many different aids. The best example would be the League for the Hard of Hearing. Otologists might then be able to send their patients to this center,

thereby helping them to get the best possible fitting.

After the war there may appear an apparatus which plays victrola records so that the human voice is heard at different intensities. There is such a machine at present, but commercial production is still in question. With such an apparatus different aids may be tested on patients to determine the most efficient one for the particular individual.

J. Kent Leasure, M.D., *Chairman*,
O. T. Allen, M.D.,
E. E. Holland, M.D.,
M. G. Erehart, M.D.,
B. D. Ravdin, M.D.,
K. L. Craft, M.D.,
H. C. Parker, M.D.

## WAR PARTICIPATION COMMITTEE

September 25, 1945.

*House of Delegates,*
*Indiana State Medical Association.*

**SUBJECT: "Sixth Annual Report."**

**Hospitals**

Difficulty has been experienced in maintaining adequate internal staff under the 9-9-9 program. The state's quota for interns is 116, and for residents 52. Our state quota for commissioned officers who receive delay in active duty orders to serve as residents has been set at 31. New graduates must apply for a commission within thirty days.

**Procurement**

In service, 1260 doctors; of this number 993 are from private practice. Three hundred seventy-five doctors were rejected. One-third of one per cent refused to apply. Separated from service, 81.

**Stringent Areas**

Number in the state, 37. Four 4-F doctors have been allocated. The majority of 4-F physicians elected not to make a patriotic contribution to the war effort by consenting to allocation. Four physicians have been released at our request; twenty-seven others are being processed for release for civilian coverage. The end of the war in Europe has added great impetus to steps looking toward the release of physicians for civilian coverage. These cases are processed through Procurement and Assignment Service. Favorable consideration is not likely to be given to:

1. Physicians of present military age; this is, thirty-eight.
2. Those on overseas duty.
3. Those assigned to duties requiring special qualifications.

Fifty per cent of the load in the state is being carried by doctors over fifty years of age. In rural counties without large centers of population, a very large proportion of the load is being carried by doctors sixty-five and beyond.

**Armed Forces**

1. *Army:* There are 45,318 doctors in the Army. It proposes to release two to three thousand by January, 1946, and perhaps 6,000 by May, 1946. An Army of 7,000,000 until V-J Day will require about 38,500 medical officers.

2. *Navy:* 12,670 doctors are in the Navy. Three thousand are urgently needed. Theoretically, there is a need ultimately of an additional 11,000—an objective impossible of attainment. During the past few months the Navy has been interested in reconsidering doctors formerly rejected.

**Complaints**

1. Army: Rank and promotion have been a headache both to the Surgeon General's Office and the medical officer. It was settled by passing the responsibility on to service commands and commanders in theatres of operation. Reserve officers called up in great numbers in 1940-1941, many in lower grades, resented doctors recruited later with higher rank but without military training.

2. Dissatisfaction with A.M.A. Doctor Henderson, a member of the Board of Trustees, has been asked to reply to the alleged indifference and lack of concern on the part of the A.M.A. as to doctors in service. He reminds us that the Procurement and Assignment Service, created by presidential directive, is a government agency and not an agency of the A.M.A. American Medical Association headquarters and officials individually have worked and fought for the welfare of doctors in service; the A.M.A. has no authority over the Army or Navy Medical Corps officers. Serious consideration has been given to complaints, and whenever feasible they have been taken up with the Surgeons General of the Army and Navy, or with the Secretaries of War and Navy.

One outstanding example: Vigorous protest resulted in abolishing the policy of assigning medical officers to the Veterans' Administration. (See General Kirk's letter, *J.A.M.A.*, 128:669, June 30, 1945.)

The A.M.A., through its Committee on Post-War Service, is arranging residencies, hospital training, and postgraduate courses; a bureau will be maintained with information as to location, licensure, and general aid. The A.M.A. is aware of the problems and has made an effort to help solve them, as it will do in meeting future problems.

3. There are other complaints, such as the assigning of medical officers to other than professional duties, release of officers from active duty, alleged surplus of doctors, et cetera. These are matters of military policy and not questions for discussion here. It may be remarked that there still remain the problems associated with the Army of Occupation, the intensified war with Japan, and the care of the sick and disabled who are kept in military hospitals until maximum recovery is reached.

**General**

Once again attention is called to the need for a rotating fund for financial aid to returning service doctors. Some states already have initiated such a step.

Selective Service has been cooperative. Relations with the Washington Procurement and Assignment Service Office have been cordial. Doctor Henderson has been helpful and loyal.

We express our appreciation of the support of Mr. Hendricks' Office, and of the invaluable assistance of the various County Procurement and Assignment Service Advisory Committees throughout the state.

We regret to report the death of one of our state committee members, Dr. C. C. Tucker, of Greencastle; also the serious illness of another member, Dr. W. M. Miley, of Anderson. Doctor Miley has been a faithful member since the inception of the M-Day Committee.

C. R. Bird, M.D., *Chairman.*
John R. Newcomb, M.D., *Vice-chairman,*
W. M. Miley, M.D.,
C. B. McCulloch, M.D.,
B. W. Chidlaw, M.D.,
Glen Ward Lee, Lt. Col. U.S.A.

## COMMITTEE ON PHYSICAL THERAPY

(No report received.)

## MEDICAL RELIEF COMMITTEE*

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

### GOOD MEDICAL CARE FOR THE INDIGENT IN INDIANA

The Medical Relief Committee of the Indiana State Medical Association met Sunday, August 5, 1945, at the Columbia Club, Indianapolis.

The policy of the Medical Relief Committee is a continuation of the policies of previous years since the organization of this committee in 1939: Good Medical Care For the Indigent of Indiana. This program is to be continued by the medical profession of Indiana in cooperation with the trustees, subordinate township officials, county officials and health officers, county and state welfare agencies, and private charitable and welfare agencies.

It is the feeling of the committee that the chief source of difficulty in administering medical aid to the indigent in the several communities of the state lies in the conflict in jurisdictional responsibility of the (1) township trustee system, and the (2) Department of Public Welfare—county, district, and state.

While the medical profession of the state is pledged to support and cooperate with the above authorities in providing good care for the indigent sick, injured, and afflicted, where jurisdictional conflict between authorities occurs in any one or several communities, the willingness and efficiency of the physician in helping is often seriously affected. Physicians, like everyone else, "cannot serve two masters."

In whatever community exists a jurisdictional problem between the trustee system and public welfare departments, clarification of such an issue by mutual understanding between the above agencies and the local county medical society will do much to enable the individual physician to work efficiently in behalf of the indigent in the community.

At this point let us remind the physicians of Indiana that:

(1) Through previous Acts of the General Assembly of Indiana in 1907, 1919, and 1929, diphtheria, scarlet fever, and tetanus antitoxins and anti-rabies virus are available to the indigent per requisition blanks provided by the local health officer and signed by the physician.

(2) Insulin is likewise available to the indigent through the medium of the general fund of the township trustee—(Acts of the General Assembly, 1935).

The township trustees in the several townships of the State of Indiana are legally *overseers of the poor*, and *each county* is mandated to maintain a county asylum or infirmary through the medium of the county council and county commissioners. (Original Acts of General Assembly of Indiana, 1907, and amended in 1935.) Matters pertaining to the legality of residencies and eligibility for aid (including medical care) are herein set forth. Senate Bill 179—Acts of the General Assembly, 1935, specifically states the following:

> "Duties of the Trustee: The township trustees shall have the oversight and care of all poor persons so long as they remain a charge. He shall in cases of necessity provide prompt medical and surgical care not provided by public institutions, and shall see that medicines, medical supplies, special diet, and nursing are provided *as prescribed by the physicians.*"

It shall be the duty of the overseer of the poor, on complaint made to him that any person within his township lying sick therein or in distress without friends or money, to examine into such case and provide care thereof.

#### State Board of Public Welfare

In 1936-1937 the physicians of Indiana, continuing to render medical aid to the indigent, assumed further responsibilities in this care in cooperation with the state and county departments of public welfare (created under Acts of the General Assembly of Indiana).

The Medical Relief Committee calls to the attention of the readers of The Journal the following:

Acts of the General Assembly: Senate Bill 14, Section 7, March 10, 1941—An Act to amend "an

* Supplementing the report of 1944, printed in The Journal of September, 1944.

act concerning public welfare" 1936: "enacted as an emergency."

*Section No. 7*—"The Public Welfare Department shall be responsible for establishing *minimum standards* for *old age recipients* and *children*, provided such standards relate to the state as a whole and shall not establish standards limited to one or two counties."

*Section No. 8*—Sub-section: "Shall provide services to county governments including the organization and supervision of county departments for the effective administration of public welfare functions, the compilation of statistics and necessary information relative to public welfare problems. Throughout the state and through the several divisions encourage research into physical and mental disability, crime, delinquency and causes of dependency."

*Sub-Section*—"Shall make rules and regulation and take such action as deemed necessary or desirable. No such rules or regulations affecting the powers, duties or functions of county or district boards or departments shall become effective until ten days after copy has been placed in the mails addressed to each county or district director."

*Sub-Section:* "Shall cooperate with the Federal Social Security Board created until Title 7 of the Social Security Act enacted by the 74th Congress and approved August 14, 1935."

*Sub-Section:* "Shall act as the agent of the Federal Government in welfare matters of mutual concern in conformity with provisions of the act, and in any Federal Funds granted to the state to aid in the furtherance of any function of the state government."

*Sub-Section:* "May, under such rules and regulations as may be prescribed by the State Department, designate county departments to serve as agents of the State Department in the performance of all public welfare activities in the county and, when necessary in the opinion of the State Board, provide *ALL* or *ANY* part of the local administrative cost and/or cost of assistance."

*Sub-Section:* "Shall administer such additional public welfare functions as are hereby or may hereinafter or hereafter be vested in it by law and provide for the progressive codification of laws which the board is required to administer."

## CONCLUSIONS

**A Study of Medical Relief as Regards Trustees, Subordinate (Advisory Board) Officers, County Officers, State Board, Federal Agencies:**

1. WHEREAS the Acts of the General Assembly of 1907 designate the township trustees of the several townships of the State of Indiana as ex-officio overseers of the poor with the power of determining the individual needs (medical, surgical and otherwise) of his constituents in legal terms of his residency in said township or townships; and

2. WHEREAS the Acts of the General Assembly of 1907 direct each county to maintain a county asylum or infirmary for such poor and indigent persons, the funds necessary to be appropriated by the county council; and

3. WHEREAS the original Act of the General Assembly of 1937 created a State Department of Public Welfare with subsidiary county welfare boards and units; and

4. WHEREAS amendments to the emergency act of 1936-37 pertaining to the State Department of Public Welfare in Acts of the General Assembly of 1939, 1941, and 1943 broaden the scope of activity and authority of the state departments and county departments—it would seem to the members of the Medical Relief Committee of the Indiana State Medical Association that:

(1) The laws of 1907 delegating the township trustees of the several townships as ex-officio overseers of the poor are:

a. Still nominally in effect.
b. That the counties are still obligated to maintain county asylums and infirmaries.

(2) That the Acts of 1937 creating a state department and county welfare department create a new official medium, (in addition to the trustee) whereby physicians administer medical aid to needy and indigent persons.

(3) That the amended acts of 1939, 1941, and 1943 broaden the scope and authority of the state and county welfare boards in administering medical care of the needy.

(4) That the co-existing laws either limit the powers of the trustees or township unit or else supersede them.

(5) That the existing acts will enable the department of public welfare (state and county) to become agents of the state and federal governments to direct *all* public welfare activities in the county and may thereby provide all or any part of the local administrative cost of assistance.

THEREFORE, we recommend that duly delegated officers and committees of the Indiana State Medical Association meet with the State Department of Public Welfare as requested by the Indiana State Welfare Board for the purpose of making better contacts with the Indiana State Welfare Board;

FURTHERMORE, that in conformance with the report of this committee of September, 1944, we advocate again that any funds for medical assistance be paid directly to the recipient and not to the physician,

THAT this committee does not favor a state-wide fee schedule but rather delegates such powers of establishing fees in keeping with local community requirements to the joint good offices of the trustees, county welfare board, and the county medical society;

FURTHER, that, in the event of complaint of irregularity in fees or service on the part of any physician administering aid to the indigent, the

local County Welfare Board inform the State Welfare Board of all the facts in the case. The State Welfare Board should then call upon the Executive Committee of the Indiana State Medical Association to take the matter up with the officers of the county medical society involved in the case, and request the county officers to take appropriate steps to correct whatever irregularities they find exist.

EUGENE F. BOGGS, M.D., *Chairman*,
JOSEPH L. ALLEN, M.D.,
JAMES L. WYATT, M.D.,
C. S. BLACK, M.D.,
ALFRED ELLISON, M.D.,
AUSTIN SWEET, M.D.,
K. L. HULL, M.D.,
J. D. VAN NUYS, M.D.

## COMMITTEE ON RURAL MEDICAL CARE

*House of Delegates,*
*Indiana State Medical Association.*

Gentlemen:

The interest in "rural health" has become increasingly the concern of farm groups. The Farm Bureau, The Grange, The Farmers Union, The Farm Foundation, and many smaller farm groups have been conferring this year on a national level with the assistance of the American Medical Association, United States Public Health Service, United States Department of Agriculture, many agricultural colleges and universities, to mention just a few who have contributed expert viewpoints, based upon many research problems.

The farm groups are largely opposed to federal legislation of the compulsory type. They are seeking a solution based on voluntary group action. The need is recognized for extensive educational programs covering the benefits to be derived from good medical and hospital care, improved public health and nursing services, if the rural communities are to take full advantage of improved facilities. It is the duty of every doctor to share in the promotion and attainment of this public welfare activity.

The Committee on Rural Medical Care has had no meetings during the year, but the chairman has attended conferences of these national groups. It is to be hoped that the medical profession will, wherever possible, give sympathetic and understanding aid in the solution of these very important problems.

F. S. CROCKETT, M.D., *Chairman*,
H. N. SMITH, M.D.,
I. H. SCOTT, M.D.,
F. A. MALMSTONE, M.D.,
GEORGE A. MAY, M.D.,
GEORGE R. DOUGLAS, M.D.,
GEORGE V. CRING, M.D.

## OPA MEDICAL ADVISORY COMMITTEE

*House of Delegates,*
*Indiana State Medical Association.*

During the past year the activities of the OPA Committee of the Indiana State Medical Association have been about the same as during the two preceding years. We were far more successful in securing more liberal diet allowances in many diseased states, and that has worked to advantage for patients throughout Indiana. In many instances the District OPA office has granted a 400 per cent increase over amounts for maximal diets distributed by the national office. These supplementary increases and better grouping of diagnoses for use in the OPA office have lessened the volume of work for the committee as well as permitted a more equitable distribution of food to needy patients.

C. L. RUDESILL, M.D., *Chairman*,
R. A. SOLOMON, M.D.,
W. M. DUGAN, M.D.

### "MEDICAL PRACTICE IN 1964

**"(Leaves from the Diary of Dr. I. M. Submerged)**

"January 1, 1964: Awakened early by signal on the two-way radio. It was Mrs. Grossflatus having another gall bladder attack. I tuned in carefully, making contact with the right upper quadrant of her abdomen. Could hear a scratching sound as the bile flowed into the cystic duct. Undoubtedly she had a stone in the gall bladder.

"April 7: I had an interview with Geheimrat Joe R. Tammany, district supervisor of Local No. 246, Amalgamated Medical Workers of America. Clever man, Tammany. It is a shame he didn't get a chance to finish grade school. I told him of my dislike for the tonsil appraisal department and inquired about a transfer. I was anxious to get to the Athlete's Foot Section. I felt I should have as varied experience as possible.

"May 9: My enthusiasm ran high. A close friend working in Central Office assured me he had seen my transfer orders on the Grand Prelate's desk. The wife and I celebrated by eating out. We packed away 7 capsules of Vitamins U, V, R and X2, together with 8 compressed tablets of steak and liver precipitate (10 grams each). For dessert we had 2 cc. of ice cream and apple pie concentrate intramuscularly in the hip.

"At 2100, we tiptoed into the bedroom to see how Junior was progressing. He was conceived three weeks ago in a test tube, by remote control.

"July 5: My orders arrived. I am being transferred to the Athlete's Foot Section as of 0700 tomorrow. No travel pay was involved, since it was only one flight up, and transportation was furnished by the state.

"September 9: Junior is four months prenatal today. He is growing nicely, having long since been moved from cramped quarters in the test-tube to a 500 cc. flask. Sure looks like he's going to be a boy.

—WAR DOCTOR."

## LIST OF PRESIDENTS OF THE INDIANA STATE MEDICAL ASSOCIATION SINCE ITS ORGANIZATION

| *Name and Residence* | *Elected* | *Served* |
|---|---|---|
| *Livingston Dunlap, Indianapolis | 1849 | 1849 |
| *William T. S. Cornett, Versailles | 1849 | 1850 |
| *Ashahel Clapp, New Albany | 1850 | 1851 |
| *George W. Mears, Indianapolis | 1851 | 1852 |
| *Jeremiah H. Brower, Lawrenceburg | 1852 | 1853 |
| *Elizur H. Deming, Lafayette | 1853 | 1854 |
| *Madison J. Bray, Evansville | 1854 | 1855 |
| *William Lomax, Marion | 1855 | 1856 |
| *Daniel Meeker, LaPorte | 1856 | 1857 |
| *Talbot Bullard, Indianapolis | 1857 | 1858 |
| *Nathan Johnson, Cambridge City | 1858 | 1859 |
| *David Hutchinson, Mooresville | 1859 | 1860 |
| *Benjamin S. Woodworth, Fort Wayne | 1860 | 1861 |
| *Theophilus Parvin, Indianapolis | 1861 | 1862 |
| *James F. Hibbard, Richmond | 1862 | 1863 |
| *John Sloan, New Albany | 1863 | 1864 |
| *John Moffett (acting), Rushville | 1864 | 1864 |
| *Samuel M. Linton, Columbus | 1864 | 1865 |
| *Wilson Lockhart (acting), Danville | 1865 | 1865 |
| *Myron H. Harding, Lawrenceburg | 1865 | 1866 |
| *Vierling Kersey, Richmond | 1866 | 1867 |
| *John S. Bobbs, Indianapolis | 1867 | 1868 |
| *Nathaniel Field, Jeffersonville | 1868 | 1869 |
| *George Sutton, Aurora | 1869 | 1870 |
| *Robert M. Todd, Indianapolis | 1870 | 1871 |
| *Henry P. Ayres, Fort Wayne | 1871 | 1872 |
| *Joel Pennington, Milton | 1872 | 1873 |
| *Isaac Casselbery, Evansville | 1873 | ..... |
| *Wilson Hobbs, Knightstown | 1873 | 1874 |
| *Richard E. Haughton, Richmond | 1874 | 1875 |
| *John H. Helm, Peru | 1875 | 1876 |
| *Samuel S. Boyd, Dublin | 1876 | 1877 |
| *Luther D. Waterman, Indianapolis | 1877 | 1878 |
| *Louis Humphreys, South Bend | 1878 | ..... |
| *Benj. Newland (acting), Bedford (v.-p.) | 1878 | 1879 |
| *Jacob R. Weist, Richmond | 1879 | 1880 |
| *Thomas B. Harvey, Indianapolis | 1880 | 1881 |
| *Marshall Sexton, Rushville | 1881 | 1882 |
| *William H. Bell, Logansport | 1882 | 1883 |
| *Samuel E. Munford, Princeton | 1883 | 1884 |
| *James H. Woodburn, Indianapolis | 1884 | 1885 |
| *James S. Gregg, Fort Wayne | 1885 | 1886 |
| *General W. H. Kemper, Muncie | 1886 | 1887 |
| *Samuel H. Charlton, Seymour | 1887 | 1888 |
| *William N. Wishard, Indianapolis | 1888 | 1889 |
| *James D. Gatch, Lawrenceburg | 1889 | 1890 |
| *Gonsolvo C. Smythe, Greencastle | 1890 | 1891 |
| *Edwin Walker, Evansville | 1891 | 1892 |
| *George F. Beasley, Lafayette | 1892 | 1893 |
| *Charles A. Daugherty, South Bend | 1893 | 1894 |
| *Elijah S. Elder, Indianapolis | 1894 | ..... |
| Charles S. Bond (acting), Richmond | 1894 | 1895 |
| *Miles F. Porter, Fort Wayne | 1895 | 1896 |
| *James H. Ford, Wabash | 1896 | 1897 |
| *William N. Wishard, Indianapolis | 1897 | 1898 |
| *John C. Sexton, Rushville | 1898 | 1899 |
| *Walker Schell, Terre Haute | 1899 | 1900 |
| *George W. McCaskey, Fort Wayne | 1900 | 1901 |
| *Alembert W. Brayton, Indianapolis | 1901 | 1902 |
| *John B. Berteling, South Bend | 1902 | 1903 |
| *Jonas Stewart, Anderson | 1903 | 1904 |
| *George T. MacCoy, Columbus | 1904 | 1905 |
| *George H. Grant, Richmond | 1905 | 1906 |
| *George J. Cook, Indianapolis | 1906 | 1907 |
| *David C. Peyton, Jeffersonville | 1907 | 1908 |
| *George D. Kahlo, French Lick | 1908 | 1909 |
| *Thomas C. Kennedy, Shelbyville | 1909 | 1910 |
| *Frederic C. Heath, Indianapolis | 1910 | 1911 |
| *William F. Howat, Hammond | 1911 | 1912 |
| *A. C. Kimberlin, Indianapolis | 1912 | 1913 |
| *John P. Salb, Jasper | 1913 | 1914 |
| *Frank B. Wynn, Indianapolis | 1914 | 1915 |
| *George F. Keiper, Lafayette | 1915 | 1916 |
| *John H. Oliver, Indianapolis | 1916 | 1917 |
| *Joseph Rilus Eastman, Indianapolis | 1917 | 1918 |
| William H. Stemm, North Vernon | 1918 | 1919 |
| *Charles H. McCully, Logansport | 1919 | 1920 |
| *David Ross, Indianapolis | 1920 | 1921 |
| William R. Davidson, Evansville | 1921 | 1922 |
| *Charles H. Good, Huntington | 1922 | 1923 |
| *Samuel E. Earp, Indianapolis | 1923 | 1924 |
| E. M. Shanklin, Hammond | 1924 | 1925 |
| Charles N. Combs, Terre Haute | 1925 | 1926 |
| *Frank W. Cregor, Indianapolis | 1926 | 1927 |
| George R. Daniels, Marion | 1926 | 1928 |
| Charles E. Gillespie, Seymour | 1927 | 1929 |
| *Angus C. McDonald, Warsaw | 1928 | 1930 |
| Alois B. Graham, Indianapolis | 1929 | 1931 |
| Franklin Smith Crockett, Lafayette | 1930 | 1932 |
| Joseph H. Weinstein, Terre Haute | 1931 | 1933 |
| Everett E. Padgett, Indianapolis | 1932 | 1934 |
| *Walter J. Leach, New Albany | 1933 | 1935 |
| Roscoe L. Sensenich, South Bend | 1934 | 1936 |
| *Edmund Dougan Clark, Indianapolis | 1935 | 1937 |
| Herman M. Baker, Evansville | 1936 | 1938 |
| Edmund M. Van Buskirk, Fort Wayne | 1937 | 1939 |
| Karl R. Ruddell, Indianapolis | 1938 | 1940 |
| Albert M. Mitchell, Terre Haute | 1939 | 1941 |
| M. A. Austin, Anderson | 1940 | 1942 |
| C. H. McCaskey, Indianapolis | 1941 | 1943 |
| J. T. Oliphant, Farmersburg | 1943 | 1944 |
| N. K. Forster, Hammond | 1944 | 1945 |

** Deceased.*

## DATA FROM PREVIOUS SESSIONS

| *Year* | *Session* | *Place* | *Registration* |
|---|---|---|---|
| 1908 | 59th | French Lick | 312 |
| 1909 | 60th | Terre Haute | 421 |
| 1910 | 61st | Fort Wayne | 450 |
| 1911 | 62nd | Indianapolis | 748 |
| 1912 | 63rd | Indianapolis | 590 |
| 1913 | 64th | West Baden | 312 |
| 1914 | 65th | Lafayette | 527 |
| 1915 | 66th | Indianapolis | 646 |
| 1916 | 67th | Fort Wayne | 381 |
| 1917 | 68th | Evansville | 270 |
| 1918 | 69th | Indianapolis | 388 |
| 1919 | 70th | Indianapolis | ..... |
| 1920 | 71st | South Bend | 421 |
| 1921 | 72nd | Indianapolis | 550 |
| 1922 | 73rd | Muncie | 522 |
| 1923 | 74th | Terre Haute | 823 |
| 1924 | 75th | Indianapolis | 1,012 |
| 1925 | 76th | Marion | 800 |
| 1926 | 77th | West Baden | 900 |
| 1927 | 78th | Indianapolis | 1,500 |
| 1928 | 79th | Gary | 892 |
| 1929 | 80th | Evansville | 814 |
| 1930 | 81st | Fort Wayne | 1,115 |
| 1931 | 82nd | Indianapolis | 1,033 |
| 1932 | 83rd | Michigan City | 904 |
| 1933 | 84th | French Lick | 637 |
| 1934 | 85th | Indianapolis | 1,814 |
| 1935 | 86th | Gary | 1,011 |
| 1936 | 87th | South Bend | 1,150 |
| 1937 | 88th | French Lick | 1,154 |
| 1938 | 89th | Indianapolis | 1,751 |
| 1939 | 90th | Fort Wayne | 1,332 |
| 1940 | 91st | French Lick | 1,064 |
| 1941 | 92nd | Indianapolis | 1,890 |
| 1942 | 93rd | French Lick | 706 |
| 1943 | 94th | Indianapolis | 1,323 |
| 1944 | 95th | Indianapolis | 1,584 |
| 1945 | 96th | French Lick | ..... |

# Military News

Captain Fred O. Clark, of Syracuse, has been transferred from Esler Field, Louisiana, to Kelly Field, Texas.

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Major Charles A. Reid, of Indianapolis, is now transport surgeon aboard a United States Army transport.

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Captain Kenneth L. Shaffer, of Vincennes, is at Fort Sheridan, Illinois, having been transferred there from Percy Jones General Hospital, Battle Creek, Michigan.

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Captain Alfred J. Dainko, of Whiting, is at the Seymour Johnson Field, at Goldsboro, North Carolina, after being transferred there from Craig Field, at Selma, Alabama.

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Lieutenant Commander Russell S. Henry, of Indianapolis, is now on duty with a photofluorographic unit at a San Francisco fleet post office address.

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Major Herman L. Watson, of Evansville, has been transferred to the regional hospital at Camp Maxey, Texas. He was formerly at Charleston, South Carolina.

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Another Indiana physician who has recently gone to Camp Blanding, Florida, is Captain Everett W. Thomas, of Leesburg, who is at the regional hospital there. He was formerly stationed at Asheville, North Carolina.

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We have learned that Lieutenant Commander Erwin E. Blackburn, of South Bend, is at sea somewhere in the Pacific. He is on board a combat transport.

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Formerly stationed at the Winter General Hospital, in Topeka, Kansas, Lieutenant Colonel John H. Greist, of Indianapolis, is now neuropsychiatric consultant at the Seventh Service Command, Omaha, Nebraska.

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In addition to a Presidential Unit Citation and four bronze battle stars, Captain Ralph V. Everly, of Indianapolis, has also been awarded a bronze star for his assistance in the liberation of personnel interned in Switzerland. Captain Everly was on duty as squadron surgeon for the Eighth Air Force, but has recently been home on a thirty-day leave.

Dr. Clarence E. Reich, of Evansville, has recently been awarded his captaincy. He is stationed at Camp Adair, Oregon.

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Dr. Joseph J. Spalding, of Indianapolis, has recently received his captaincy. He is stationed at the Gardiner General Hospital, in Chicago.

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Captain John W. Woner has returned to Linton for a thirty-day leave following thirty-three months overseas in the European Theatre.

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Captain William M. Kendrick, of Indianapolis, is on duty as the Assistant Chief of Medical Service at the general hospital on Guam.

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After eighteen months in the C. B. I. Theatre, Lieutenant David F. Stone, of Indianapolis, is now stationed at the Separation Center, at Camp Atterbury.

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After being stationed in the Pacific, Major James T. Pebworth, of Indianapolis, has returned to the United States, and is now stationed at the Regional Hospital at Fort Knox, Kentucky.

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Lieutenant Commander D. Hamilton Row, of Indianapolis, is at the Naval Dispensary, in Washington, D. C., where he is doing eye work. He recently spent ten days in Indianapolis.

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After serving a year and a half in New Guinea, Major George Plain, of South Bend, is now in Manila. He expects to return to the United States soon.

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Major Robert H. Wiseheart, of Lebanon, has been home on leave after serving as a flight surgeon in Russia. He has been overseas for two years, and had also served in North Africa.

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Captain Mars B. Ferrell, of Fortville, has been stationed on Okinawa since May, and will probably be assigned to the army of occupation. He is flight surgeon with a squadron of A-26's in the Seventh Air Force. After taking his flight surgeon's training at Randolph Field, Texas, Captain Ferrell was stationed at various airfields in the United States. At one time he was stationed at Alamogordo, New Mexico, the now famous place where the atomic bomb was first tested.

Dr. Carl M. Porter, of Jasonville, arrived from England recently after thirty-six months overseas' duty.

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Major Robert L. Amos, of New Castle, is now in Europe awaiting transportation to the C.B.I. Theatre.

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Formerly at Camp Barkeley, Texas, Captain Joe H. McCool, of Evansville, is now stationed at Camp Bowie, Texas.

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Major Walter C. Anderson, of Terre Haute, is stationed at the Army Air Force Hospital, at Marfa, Texas.

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Major William M. Browning, of Indianapolis, is on duty as medical inspector for the 91st Infantry Division, which is part of the Eighth Army in Europe.

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Landing on Okinawa on D-Day plus three, Captain William P. Marshall, of Indianapolis, is still stationed there with the 31st Field Hospital.

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Captain Harold Nugen, of Auburn, has been transferred from Camp Carson, Colorado, to the Black Hills Ordnance Plant, in South Dakota.

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After three years in the South Pacific, Captain Abraham M. Owen, of Attica, has been assigned to Camp Atterbury.

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Captain A. David Mc Kinley, of Indianapolis, has been awarded the Soldier's Medal for his heroic action in trying to rescue a wounded pilot from a burning plane on Saipan, January nineteenth. Captain Mc Kinley was the Flight Surgeon on flight-line duty when the plane, in attempting to take off on a test flight, crashed and burned. The flames soon spread to a cane field and on to a large ammunition dump, setting that afire. Quite a large number of officers and men were killed or wounded. Captain Mc Kinley was critically wounded, but has now virtually recovered from his injuries. Following a convalescent leave, spent in Indianapolis with his wife and baby son, he is now at the Dibble General Hospital, in California, for a final check-up.

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We are pleased to report that Lieutenant Colonel C. B. LaDine, of Indianapolis, has been awarded the Bronze Star for meritorious service in connection with military operations of the 95th General Hospital from May 22, 1944, to February 10, 1945. Colonel LaDine was executive officer, and was in charge of the complete organization of the hospital. The hospital was transported to France shortly after D-Day, and served close behind the front lines in the Third Army. Colonel LaDine is now the executive officer of the Thayer General Hospital, at Nashville, Tennessee.

Arriving on the *Queen Mary* the latter part of June, Lieutenant Colonel George F. Green, of South Bend, has been home on a thirty-day leave.

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After returning from England, Captain Willis A. Fromhold, of Indianapolis, has had a thirty-day leave, and has been assigned to the Ashburn General Hospital, at McKinney, Texas.

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Major David I. Schwartz, of Fort Wayne, is at the Borden General Hospital, at Chickasha, Oklahoma. He was transferred to that hospital from the Brooke General Hospital at Fort Sam Houston, Texas.

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Stationed in the Philippines, Captain Joseph T. Farrell, of Indianapolis, intimates that while several months of war isn't particularly safe, he still has his health and is in one piece, although that "one piece" is about forty pounds lighter.

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In his fifth year of service in the Army, Major Chet K. Lamber, of Indianapolis, is now somewhere in China. He has seen a great deal of India and China, and has been doing some surgery since his arrival in China, in conjunction with the Chinese medical service.

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Major Ardis F. Melloh has returned from the Pacific, and has recently spent a thirty-day leave in Indianapolis.

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After being stationed with base hospitals in England and France, Captain James F. Openshaw, of Goodland, has returned to the United States.

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After spending more than forty months overseas, in the South Pacific, Captain Theodore D. Arlook is spending a thirty-day leave in Elkhart. Following his last leave in February of 1942 he went to Australia, where he was stationed for five months before going into New Guinea with the first combat divisions. Captain Arlook's decorations include the Pacific campaign ribbon with two battle stars and a distinguished unit citation.

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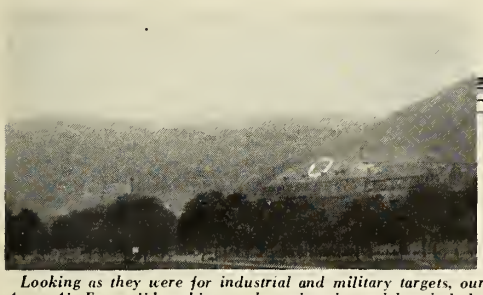
With the First Army in Germany, Captain George Colip, of South Bend, is working with an air evacuation unit on an air strip. This work of plane and glider evacuation is quite interesting, and the turnover is huge, five thousand patients having been moved in two weeks. At the end of the war in Germany they were handling mostly liberated prisoners, and will continue doing so until all concentration camps are cleaned up. After that Captain Colip expects to go on to the Pacific. Captain Colip declares that all the stories that are told of the brutality of the Germans are true, and that the conditions in some of the prison camps right after they were liberated were almost beyond description.

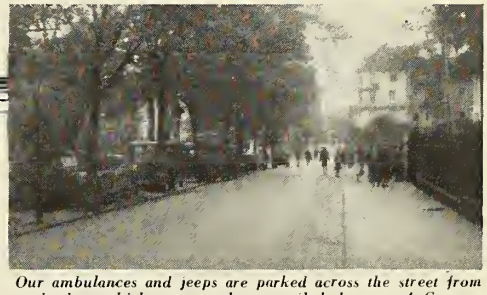
# PEACE REIGNS AGAIN IN GERMANY

Major Ralph U. Leser, of Indianapolis, who is with the 117th General Hospital, recently wrote from somewhere in Germany that he felt he had neglected us during his thirty-eight months of overseas duty, and was making a pictorial attempt to make amends. Nothing could have pleased us more, and we want our readers to share some of these pictorial stories with us, which show not only the ravages but the fallacy of war.

"Whatsoever a man soweth, that shall he also reap."

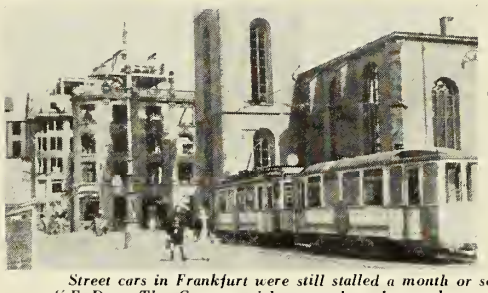


*Looking as they were for industrial and military targets, our Army Air Force did nothing to the university and hospitals located at Heidelberg, which remain intact.*



*Our ambulances and jeeps are parked across the street from a sanitarium which was run by an exiled doctor. A German nurse, doughboys, and German civilians are seen in the picture.*

*In contrast, this is a typical scene in Frankfurt. This is supposed to have been done during three days in October, 1943, and two days during March, 1944, when the British came at night with bombs, mines and incendiaries, and the Americans with blockbusters.*



*Street cars in Frankfurt were still stalled a month or so after V-E Day. The German girls seemed to know that youth is youth everywhere. They were conscious of the camera, and did not mind being photographed. The background further portrays the futility of war.*

*Remember when we heard that the Nazis had gone underground? This is a part of Hitler's, later Rundstedt's and Von Kesselring's headquarters near Bad-Nauheim. It was heavily camouflaged and consisted of many hundred yards of tunnels, et cetera, but our our Air Force found it in March and gave it and the castle a good pasting.*

*The master race is reduced to primitive methods of transport. This entire town had an allotment of two hundred fifty quarts of gasoline a month in most of 1944 and 1945. Twenty hospitals are located here. These German enlisted men are carrying hot food in a barrel-like vessel from a large hospital with a kitchen to smaller hospitals.*

*German girls looked neither to the right nor left as this one was snapped. Their parents had probably told them that we did not come as friends. At first the children asked the Americans for chocolate and gum, but it was a complete non-fraternization era with the kids—and even more so with their mamas.*

*This might be called "The face of Europe today." It was taken in late April, when the roads were full of D. P.'s (displaced persons). Often their bed was the ground, and the sky their roof. They frequently had to steal and dig in garbage pails in order to eat.*

Two Mishawaka physicians, Captain William Robert Orr, and Lieutenant Richard A. Ganser, recently have been home on leave of absence. Captain Orr has been with the 109th General Hospital, in England, and Lieutenant Ganser has been in the Aleutians.

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THE JOURNAL office was visited recently by Major John M. Palm, of Brazil, who has returned from Corsica after twenty-eight months' overseas duty. Upon completion of his thirty-day leave, Major Palm will report to Santa Ana, and he said, "I don't know what will happen after that." We noted that Major Palm was wearing the Air Medal, as well as the European-African-Middle-East campaign ribbon with three battle stars.

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Announcement has been made of the marriage of Captain A. Elizabeth Garber, M.D., a graduate of the Indiana University School of Medicine in 1939, to Major A. Conrad Tate, of Moose Jaw, Saskatchewan, Canada. The wedding took place on March nineteenth, at the St. Columbus Chapel in London. The bride is on duty with the Eighth General Dispensary in England, and has been in service since July, 1942. She was the first woman surgeon with the United States Army. The Eighth General Dispensary, to which she is attached, has been awarded the Meritorious Service Unit Plaque for superior performance of duty in the accomplishment of exceptionally difficult tasks. Major Tate is on duty with the First Canadian Special Service Battalion.

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An interesting letter was written by Major M. I. Hewitt, of South Bend, to the St. Joseph County Medical Society *Service Bulletin*, and we take the liberty of reprinting it herewith:

" 'I'm still a medical officer, if you gain the significance of that statement. This time I was fortunate enough to pull a good ship—it's really wonderful! The first time I've gone first class since I've begun these enforced, watery migrations. The one thing that has been grand aboard this ship is the food. We have had our first fresh eggs, not the machine-laid kind, in many a day. There's nothing more soul stirring than to sit down at breakfast and have those two delicious yellow eyes staring an "eggy good morning" at you. Also I have enjoyed my first toast since September, 1944. It's still a very choice article of food, and I think it should be adopted for general use.

'These trips by sea are really very restful, and we have much time to catch up on our reading and our sleep. The way I have it calculated, I have during this trip engaged in the pleasant escapades of Morpheus to the degree that after we have arrived I shall have a sleep credit extending to the 17 July 1946. So much for my very uninteresting, non-contributory existence.

'I presume that after the end of the European conflict some doctors should be returning home discharged, and should be able to help all of you out after the swell job you have done in taking care of those at home that we left in your care. I know I really have appreciated it in my own case.

'I don't know where we're going or what we shall do. It will no doubt have something to do with the war out here. Anything we can do to get this thing over quickly is for my money at this stage'." (And it is finally over!)

After serving for many months in the Southwest Pacific, Major Joseph E. Kopcha, of Whiting, has returned to this country and has recently completed a sixteen-week intensive course at the School of Aviation Medicine, at Randolph Field, Texas.

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A letter from Captain O. R. Wilson, of Shelbyville, indicates that he is now on duty with a station hospital at a San Francisco A.P.O. He wrote, "Since we left our last location we have entered the West Pacific and have built a new hospital. Thus far the only outstanding thing here is the extreme lack of disease. For this we are all thankful."

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Captain Elmer G. Koehler is now on terminal leave in Elkhart, awaiting official confirmation of his discharge because of disability incurred in combat service in Europe. Captain Koehler was with the Fourth Division, the first American unit to enter Cherbourg, the first American infantry unit to enter Paris, and later Germany, at Lunebach, on September thirteenth. He was returned to the United States on the hospital ship *Chateau-Thierry* and has been hospitalized at the Wakeman Convalescent Hospital, at Camp Atterbury.

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The Legion of Merit, the second highest award bestowed by the United States, has been awarded to Commander C. W. Olcott, of Aurora, who has been serving in the Pacific as division surgeon of a Marine division since August, 1944. The citation states that the award was made "For exceptionally meritorious conduct in the performance of outstanding service while serving as the medical officer of the Assistant Division Commander and as division surgeon of a Marine Division during the seizure of Iwo Jima, Volcano Islands, from February 19 to March 26, 1945. Landing early in the afternoon of D-Day amidst heavy artillery, mortar, and small-arms fire, Commander Olcott, with disregard for his own personal safety, and with expert administrative ability and professional skill, coordinated and directed the medical activities of the units of the division ashore. Commander Olcott assumed the duties of division surgeon on February 21, and with his previously-demonstrated untiring devotion to duty, resolute courage, and superior technical knowledge supervised and directed the treatment of the many casualties, evacuation of the wounded, and the installation and operation of the division hospital, which treated three thousand, six hundred and ninety-three cases. On numerous occasions, under heavy fire, he courageously inspected the aid stations in the forward areas, inspiring the officers and men by his coolness under fire, unwavering devotion to duty, and broad technical knowledge. His meritorious service, professional skill, intrepidity, and devotion to duty materially aided the successful conduct of the operation and were in keeping with the highest traditions of the United States Naval Service.

Captain Paul A. DesJean, a graduate of the Indiana University School of Medicine, in 1942, entered service on completion of his internship at the medical center in 1943, and has recently been home on leave after returning from Germany. Captain DesJean was awarded the Bronze Star in May for meritorious service at Metz, and the reduction of the Ruhr pocket. At the end of his leave he reported to Camp Shelby, Mississippi, where he is now stationed. Another Indiana physician, Colonel Walter M. Stout, of New Castle, is the post surgeon and commanding officer of the hospital at Camp Shelby.

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The St. Joseph County Medical Society *Service Bulletin* has published some excerpts giving an account of "life in India," as portrayed by Captain Frederic G. Perry, of Plymouth, and we are quoting therefrom for the benefit of our readers:

"May 5, 'Received a package mailed Valentine Day, today—nuts, anchovies, tongue, and razor blades. Ate a can of anchovies before I went out to a Chinese restaurant near here, and nearly cleaned them out—a whole chicken and chow mein with "flied lice" (fried rice). It cost four dollars and was worth every cent. You should see the joint! Two years ago I would have gagged and condemned the place, but months of "C" rations changes one's ideas, especially where there is fresh fried chicken and French-fried potatoes—French-fried potatoes cooked by the Chinese in India and eaten by a Hoosier from the United States!

"Raining like h— and the tent leaks. The only dry spot is my sack with a raincoat laid on top of the mosquito tent. Have been in bed as early as eight and up at six since we have been here, mainly because it's the only dry spot; secondly, because the candles keep blowing out; and thirdly, because there is nothing else to do. It's a great life!'

"May 10, 'Nothing new worth mentioning; the point system has gone into effect, and I led the squadron (in officers) for an early separation from the service. Of course, there seems to be one minor hitch—medical officers have no replacements and hence are "essential for military operations."

"For the first time in nearly eighteen months I am under a roof, a thatched roof that leaks, and on a floor—a moist cement floor. Even so the basha is located in the shade and is much cooler and more comfortable than the tent I occupied a year ago at this time.

"Last Sunday I flew to a Burmese village located near a large jade mine, and bought a few pieces of jade. It was a real experience. The Burmese seem nice, courteous, fairly clean, happy, and intelligent—intelligent enough to know the value of jade, and difficult to bargain with. Outside the door and under a saw used to cut jade ore lay a pile of uncut and unpolished jade, probably a bushel-basketful. I picked up a rock about the size of my fist and asked, "How much?" I really half expected him to give it to me, or to pay a couple of rupees for it. After spitting on it to clean off the dirt, rubbing it with his finger, and squinting at it in the sun, he said, "Two hundred and fifty rupees." That's about seventy-five dollars. Needless to say, I didn't buy it. In the village the law of supply and demand seemed unheard of. The supply of jade was great, every woman wore jade buttons and at home had a stack of cut and polished jade for sale. The demand was poor; there is no large collection of soldiers close by, yet the prices remain high. I paid about fifteen dollars for two small pieces. We watched the cutting and handpolishing, and got a big kick out of it. Had a geologist, who is one of our photo officers, tell me the one piece is worth about thirty-five dollars. Hope he is correct.' "

As stated in a previous issue, General Hospital No. 32 — the Indiana hospital — is stationed at Aachen, Germany, and we have learned that it has been one of the busiest general hospitals in Europe. Its normal capacity is approximately one thousand patients. Most admissions now are jeep-accident victims, soldiers suffering from wounds inflicted by souvenir guns, postwar battle casualties, and soldiers who refused hospitilization until after the Germans had surrendered. Emergency treatment has been given to Germans injured by mines and booby traps, which are still a menace.

About a dozen buildings comprise the home of the hospital; it operates chiefly in a modern eight-story building that suffered only minor bomb damage. Some German equipment has been salvaged and is now in use.

During the fighting, the hospital's rest club was a haven to war-weary soldiers who visited it on forty-eight-hour passes. They reveled in the hot-mineral baths, the well-cooked food, the bed with clean sheets—matter-of-fact things for many people, but luxuries to a tired, grimy fighter who was a few miles away from the front for a few hours. There is also a bar, a billiard room, free movies, and a modern barbershop. It is not surprising then that the club is rated as one of the best in the European Theatre.

A great deal of cement, gravel, and structural steel was found when Aachen was taken, and from this material an outdoor theater, tennis courts, and parking lots have been constructed. A palatial mansion is serving as the Officers' Club; it's former owner is in jail.

High praise has been accorded the hospital by Major General Paul R. Hawley, chief surgeon of the European Theatre of Operations, who is himself a native of West College Corner, Indiana, having received his pre-medical training at Indiana University, and who has written President Herman B Wells, praising "the superb quality of the medical personnel that came with this unit," which, he added, "had professional standards that 'never varied' despite detachment of some of its members to assist other units." General Hawley said that because of his association with the university, it was necessary for him to be more critical of the Indiana hospital than any other so that it would not appear that he was showing partiality. General Hawley stated that he believed that the personnel realized this, and always made a special effort never to let him down. He also stated that he found himself at a loss to describe the superb quality of the medical personnel which comprised the 32nd General Hospital, and that they performed their duties with complete satisfaction.

According to a late war department announcement received by Dean W. D. Gatch, the hospital will be placed on the inactive list as part of the nation's postwar military establishment.

# News Notes

The appointment of Dr. Otho R. Lynch, of Peru, head of the hospital activities at the Muscatatuck State School, at Butlerville, recently has been announced.

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Appointment has been made of Dr. C. W. Dahling, of New Haven, as a member of the National Advisory Committee of Valparaiso University, by unanimous vote of the Board of Directors of the University.

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### EXAMINATION BY AMERICAL BOARD OF OPHTHALMOLOGY

Because of transportation difficulties, the examination of the American Board of Ophthalmology originally scheduled for Chicago, in October, 1945, has been postponed to January 18-22, 1946.

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Due to ill health, Dr. Lewis C. Rentschler, of Clay City, has resigned as county health commissioner. The Board of Commissioners has appointed Dr. Robert Maurer, of Brazil, to fill this position. Doctor Rentschler has also announced his retirement after thirty-three years of practice in Clay County.

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The Marion County chapter of the national fund for infantile paralysis has approved requests for new equipment at the Indianapolis City Hospital, at an expenditure of approximately $6,700. The equipment includes an additional respirator, equipment for administering the Kenny treatment, a whirlpool bath, ultraviolet lights, and a diathermy machine.

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The reappointment of three superintendents of state institutions has been announced by Governor Ralph F. Gates. The physicians are Dr. W. C. Van Nuys, of the Indiana Village for Epileptics; Dr. H. B. Pirkle, of the Indiana State Sanitorium, at Rockville, and Dr. J. V. Pace, of the Southern Indiana Tuberculosis Hospital, at New Albany.

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It is interesting to note that Dr. W. T. Lawson, of Danville, a pioneer in Hoosier Medicine, was born in a log cabin near Hillsboro, Ohio, the same year that the Indiana State Medical Association was organized. The association was then located in a frame building in Indianapolis, where the English theater now stands. The state association is still going strong, and so is Doctor Lawson, for on September 3, 1945, he celebrated his ninety-sixth birthday—and is still doing general practice. Congratulations Doctor Lawson! Hoosier Medicine is looking forward to celebrating its centennial year with you.

### MEETING CANCELED

The annual scientific and clinical session, for 1945, of the American Congress of Physical Medicine has been cancelled. This meeting was to have been held in New York City, September 5 to 8, 1945.

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A one-hundred-thousand-dollar expansion program has been approved by the board of directors of the Welborn Baptist Hospital in Evansville. The new addition will include a three-story wing which will provide twenty-four additional private rooms, eight private maternity rooms, an enlarged obstetrical division, and remodeling of the lobby, library, sunroom, and basement.

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Dr. Herman G. Haffner, of Fort Wayne, has recently returned to Fort Wayne after serving three years in the Army Medical Corps, and has announced that he will resume his practice of dermatology in the near future. Doctor Haffner's last station was at Camp Campbell, Kentucky. He served with the rank of captain as head of the Dermatology and Allergy departments of the three-thousand-bed hospital there.

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### COURSE IN CLINICAL ALLERGY

The School of Medicine, University of Pittsburgh, offers an Orientation Course in Clinical Allergy, under the sponsorship of The American Academy of Allergy, for five days, October 1 to 5, 1945, inclusive, at the School on Bayard Street, Pittsburgh, Pennsylvania. Fee, forty dollars; for veterans, servicemen and residents, ten dollars. Registration for evening round-table conferences only by special arrangements.

Inquiries should be addressed to William S. McEllroy, M.D., Dean, School of Medicine, University of Pittsburgh, Pittsburgh 13, Pennsylvania.

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Dr. E. H. Clauser, of Muncie, has been named a member of the council set up under the law enacted by the last session of the legislature, which required all hospitals in Indiana to meet certain standards of efficient care of patients. The licensing and inspection of hospitals is to be done by the Indiana State Board of Health, but the council will formulate the rules and regulations, prescribe minimum requirements, and conduct hearings on revocations.

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Dr. George Tennis has opened an office in the Alamo Building, in Greencastle, for the practice of medicine.

## POSTGRADUATE COURSES PLANNED BY INDIANA UNIVERSITY SCHOOL OF MEDICINE

Dean W. D. Gatch has announced that the faculty of the Indiana University Medical Center has prepared the following plans for postgraduate instruction. Already a large number of physicians in the service, or lately discharged from service, have inquired as to the postgraduate work they can get at the medical center. They have found the requirements for instruction of these applicants too varied to be met by a single "refresher course" of any kind, and therefore plan to give five different types of postgraduate instruction.

1. A general review of the entire subject of clinical medicine adapted to the needs of general practitioners who can take but a limited time for postgraduate study: This course will consist of lectures, demonstrations, and dry clinics. A detailed outline of this course has been prepared by Dr. Henry Mertz and his committee.
2. A thorough course in the basic sciences of anatomy, applied physiology, and pathology: This is for men who are preparing for their national board examinations. Work in it will be systematic, detailed, and thorough . Men taking this course must give at least six months' time thereto. It will be accepted as a part of the postgraduate requirements of the national boards. It will be given to our own residents. Physicians who have residencies in hospitals which are unable to give instruction in the basic sciences can get it in this course.
3. Externe work in the University and City hospitals: Students taking this work will be in residence on the University campus, just as our senior student externes are now. They will do approximately the work which senior externes do. They will have the advantage of intimate contact with patients, and will be thoroughly trained in modern methods of diagnosis and treatment. Students taking this course will be expected to devote from three to six months to it.
4. A continuation of our present, well-established program for the training of residents.
5. Extension courses given at hospitals in various parts of the state: The Indiana University School of Medicine has for the past year conducted one of these courses at the St. Elizabeth Hospital, in Lafayette, and has received invitations to give them in several other hospitals in the state. The purpose of these courses is to make hospitals, having 150 beds or more, teaching centers, conducted by faculties elected by the hospital staffs. This plan is designed to give every physician the opportunity for continuous and interesting postgraduate work in his home community.

The Indiana University School of Medicine does not have, at present, the teaching force or facilities to carry out this entire program. However, it has already been started, and its faculty is determined to give all the proposed courses at the earliest possible time.

## VETERANS ADMINISTRATION NEEDS DOCTORS

Mr. B. C. Moore, manager of the Veterans Administration Facilities, at Indianapolis, submitted the following letter, asking that it be published in THE JOURNAL because of the expanding medical services of the Veterans Administration. Doctors are needed on either a full-time, part-time, or fee basis.

**VETERANS ADMINISTRATION**
**Indianapolis, Indiana**

"Thomas H. Hendricks, Executive Secretary,
Indiana State Medical Association,
Indianapolis, Indiana.

"My dear Mr. Hendricks:

"As you are aware, with the cessation of hostilities a tremendous load of examinations and treatment of discharged veterans will be required by the Veterans Administration. No one can realize the magnitude of this problem. Because of this load, and in order that expeditious service may be rendered the discharged veterans, it will be necessary to utilize the services of private physicians to examine and treat veterans in their home localities. Under existing regulations, the administrator may appoint a physician to perform these services.

"The fees allowed are five dollars for a general examination, which consists of a complete physical examination, including temperature, blood pressure, pulse recordings, and a chemical examination of the urine. Should the patient's condition require an examination at home, an additional $3.00 per hour travel time may be authorized. The fee for treatment is as follows: Office visit, $2.00; home visit, day—$3.00; home visit, night—$5.00.

"At present the Veterans Administration maintains several designated examiners on the roster who are located throughout the State of Indiana. Several of these examiners are now serving with the armed forces, and obviously the physicians are not available. It is believed that if this matter is called to the attention of physicians throughout the State of Indiana by publication of this communication in the State Journal, that a definite service will be rendered to the veteran and to the Veterans Administration.

"Although hostilities have ceased, the medical profession is faced with the problem of rehabilitating the ill and the injured veteran. We are well aware of the fact that the medical profession has always responded when called.

"Very sincerely yours,
B. C. Moore, *Manager.*"

## PACIFIC MEDICAL CONFERENCE

One of the most important medical meetings of this war was held in the office of The Surgeon General, Washington, D.C., on July 30, 31, and August 1, and was attended by outstanding experts in surgery, medicine and disease control from all theatres of operation throughout the world.

Major General Norman T. Kirk, the Surgeon General, called the meeting "to pool the knowledge and experience of the men from the fighting fronts in order that the lessons learned thus far in the war can be more thoroughly applied than ever before in the conservation of human life."

In addition to about forty of the country's leading medical experts from the overseas theatres, General Kirk had officers from virtually every division and branch of the Office of The Surgeon General attend the meetings and thoroughly discuss all phases of medical and surgical care, supply, transportation, training, and related subjects.

Such problems as the redeployment of millions of men to the Pacific areas were discussed. It was pointed out that the transfer of such vast numbers of American troops will invariably present health problems, but does not make the job impossible or unnecessarily difficult because of the experience of three and one-half years of facing and successfully fighting and controlling disease hazards of these areas.

More effective means for the treatment and care of both wounded and sick troops near the front was another principal question studied at the meeting. It has been proved in the campaigns to date that such care has paid great dividends in the saving of lives and the alleviation of suffering, and the methods used are to be extended as far forward and as rapidly as is humanly possible.

Prevention and treatment of tropical disease were among the major problems studied and discussed at the meeting. Medical Corps specialists declared, however, that because many of these diseases are unknown in the United States, a dread of them has been created out of all proportion to their actual harmfulness.

The problem of returning medical personnel who have served several years in Pacific areas to the United States and replacing them with personnel from this country and the European and Mediterranean Theatres was given special study.

"Many of these men have well earned their relief from duty there, and many are eligible for discharge," General Kirk said. "As rapidly as replacements can be sent, these men will be returned to the United States."

He added, "From the lessons learned thus far we believe that front-line medical care and the prevention and cure of disease can be perfected, and the men meeting here know best how it can be done. Insofar as is humanly possible, no mistake made before will be repeated."

## INDIANA UNIVERSITY NEWS NOTES

Lieutenant Colonel T. G. Blocker, chief of plastic service, Wakeman General Hospital, Camp Atterbury, gave the annual lecture sponsored by the Phi Delta Epsilon medical fraternity at the Indiana University Medical Center, July 20. The lecture, which was open to members of the medical profession of the Indianapolis area, was on the subject "Plastic Surgery of War Wounds."

The meeting also was featured by the presentation to Donald P. Morgan, of Indianapolis, sophomore student at the Indiana University School of Medicine, of the John F. Barnhill Award for excellence in freshman anatomy. The presentation was made by Dr. Edwin N. Kime, professor of Anatomy at the Indiana University School of Medicine.

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Fifty-two civilian students, all but four of whom are residents of Indiana, and fourteen of whom are women, have been announced by Dean W. D. Gatch as having been accepted for admission to the Indiana University School of Medicine in September.

The civilian entering group will be augmented by thirty-six men chosen by the Navy, making a total freshman medical class of eighty-eight, which Dean Gatch described as "gratifying in view of the war depletion of qualified applicants and the decision of Selective Service more than a year ago to grant no general deferments for pre-medical students." Pre-war entering classes averaged about 120 members, which is the limit of the school's facilities.

The civilian students accepted for admission are as follows: Alda Grey Duckworth, Leslie F. Fox, William B. Johnson, Jr., Robert C. Miller, Michael O. Monar, Henry G. Nester, Horace M. Powell, Jr., John W. Stuart, and Douglas H. White, Jr., Indianapolis; Paula Jayne Bailey and Billie Bichacoff, Fort Wayne; Albert L. Blake, Mount Vernon; Grover C. Boling and William R. Stilwell, Crawfordsville; Malcolm D. Bray, Westfield; Robert W. Cleveland, Hammond; Thomas K. Craigmile, Oakville; Roland I. Davies, Tipton; Shirley Davis, Clarks Hill; Shirley Eldridge, Boswell; Etervina Figueroa, Mabel Ruth Foster, and Franklin Zeller, Bloomington; Daniel A. Gard, Connersville; Helen Geyer, Madison; Howard M. Gish, Delphi; Charles E. Glaser, Edmund S. Higgs, and Elmer E. Peters, Brookville; Noel S. Graves, Muncie; Nellie Greenburg, Wingate; Lois Herendeen, Rochester; Ida Mae Hudson, New Castle; Max E. Johnson, Decatur; Robert E. McCullough, Brazil; James W. Oberfell and Mimi Delores Slominski, South Bend; Martin H. Perle, West New York, New Jersey; Sylvan H. Perlov and Barnett Zumoff, Brooklyn, New York; John A. Peterson, Whiting; William T. Raney, Anderson; Emma Lou Sailors, Wabash; Robert K. Scott, Frankfort; Nicholas Seledsow, Gary; Leonard R. Smith, Chicago, Illinois; Margaret Ann Snow, Evansville; Lain Tetrick, Greensburg; George T. Tindall, Greenfield; Frank C. Waltz, Hagerstown; and Charles A. Yale, Jr., Fairmount.

## REVERIE

### LOAFING

I am in receipt of a letter from ye editor of the State Journal, but since he states that it is one of sixty he is sending out, I am not flattered by his S.O.S. asking for "specialists" to crystallize their experiences for the benefit of THE JOURNAL readers. Modern medical literature has wasted too much of my time reading things one wants to forget, save as historic steps in the rapid progress of our war against disease and death. Toxin antitoxin, scarlet fever antitoxin, the fifty-seven varieties of rabbit serums for pneumonia, and even the arsenicals and the sulfa drugs had their day and were followed by a partial black-out at night. It is to be hoped that penicillin may be able to avoid some of the tragedies associated with some of our former overpublicized specifics. Perhaps it is a good thing that most of our specialists are in the Army and that regulations prohibit them from writing so much "cum laude cum bunkum" as we had to read before the war.

As a specialist in essays for the *Asbestos Archives*, I think my choice of subject a very pertinent one also for THE JOURNAL, but am keeping a copy for the *Archives* in case the Editorial Board has other opinions. Loafing can be a career, a hobby, a diversion, or a schizophrenic excuse for doing nothing permanently outside restraint. It can be used destructively or constructively. It can be either a refreshing or a devastating experience. It can give you sunburn or frozen feet. It can make you either an ichthyologist or a plain liar. One can be ultrasophisticated or ultraprimitive, and both classes are to be pitied.

Perhaps the most I obtained from three years with a preceptor some forty-five years ago was this axiom: "A professional man who cannot make a good living in eleven months each year will not make a better one if he works twelve." He and his family and his profession are all beneficiaries when he learns to enjoy himself in a different environment for a month or two. And the money I've spent in following my wandering feet to Vera Cruz and Dawson, to Boston and Seattle, to Miami and Los Angeles, and to New Orleans and Quebec are assets no tax collector can ever levy upon.

But even travel can become a stale experience, and so I found a little white house on the side of a road where I could rest and read and re-live old-time reveries. And while the road is back of the house, the other side faces a beautiful lake, and from my open porch I vicariously go fishing in any of the many boats that ply its waters. My next-door neighbor brought in a six-and-a-quarter


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One Week Course Surgery of Colon and Rectum September 10. Twenty-hour Course Surgical Anatomy October 8.

GYNECOLOGY—Two Weeks Intensive Course October 22. One Week Personal Course Vaginal Approach to Pelvic Surgery September 17.

OBSTETRICS—Two Weeks Intensive Course October 8.

ANESTHESIA—Two Weeks Course Regional, Intravenous and Caudal Anesthesia.

ROENTGENOLOGY—Courses in X-ray Interpretation, Fluoroscopy, Deep X-ray Therapy every week.

UROLOGY—Two Weeks Course and One Month Course every two weeks.

CYSTOSCOPY—Ten-Day Practical Course every two weeks.

GENERAL, INTENSIVE AND SPECIAL COURSES IN ALL BRANCHES OF MEDICINE, SURGERY AND THE SPECIALTIES.

TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL.

Address: Registrar, 427 South Honore Street, Chicago 12, Illinois

pound, large-mouth black bass the other night and wakened all the neighbors to see it. But I, also know he has fished every day for a month and scarcely got a mess before this lucky strike. I'm a three hours' drive from my office, ten miles from a railroad station, and lack some modern conveniences, but miss none of them. I've learned many trades, doing odd jobs of plumbing, electric wiring, carpentry, painting, and even dug out a stretch of drain tile. And I've not gone hungry when the cook has been indisposed. I can step from my dock onto a little excursion boat that makes an hour's trip around the lake each evening, and from its deck I can watch the end of a perfect day as the sun drops behind the horizon. A pile of magazines and a few books, some old and some new, provide me with instruction and entertainment. And my typewriter is always handy to put down sentences that I find later occasion to use.

No man's day should ever be so long that it demands an extra drink of whisky to keep him going. No man's bank account is worth a coronary or a cerebral accident. And what fools men are to work themselves to death, paying big insurance premiums. Too often the insurance gets the widow a luxury-loving, second husband who can easily make her forget that her first husband had no time for leisure, for luxuries, for loving, or for LOAFING.

M. A. AUSTIN, M.D.

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**RADIO CALENDAR**

"YOUR HEALTH IN WARTIME"

Hear these broadcasts each week:

Indiana State Medical Association — "Doctor Goodhealth"—Monday, 2:00 P.M., WFBM, Indianapolis.

Vigo County Medical Society—Thursday, 12:15 P.M., WBOW, Terre Haute.

St. Joseph County Medical Society — Friday, 1:45 P.M., WSBT, South Bend.

Howard County Medical Society—Friday, 6:30 P.M., WKMO, Kokomo.

Vanderburgh County Medical Society — Saturday, 10:00 A.M., WGBF, Evansville.

# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION

### EXECUTIVE COMMITTEE

August 5, 1945.

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; N. K. Forster, M.D.; J. E. Ferrell, M.D.; F. T. Romberger, M.D.; E. M. Shanklin, M.D.; A. F. Weyerbacher, M.D.; T. A. Hendricks, executive secretary, and Ray E. Smith, assistant executive secretary.

Luncheon meeting guests: (*Those so marked were present).

*Leroy E. Burney, M.D., State Health Commissioner.
*Robert W. Jewett, M.D., director, Maternal and Child Health, Indiana State Board of Health.
*John Hewitt, M.D., chairman, Committee on Rehabilitation, Indiana State Medical Association.
*Carl D. Martz, M.D., Acting Medical Consultant, Vocational Rehabilitation Division, Indiana State Board of Vocational Education.
*Thurman B. Rice, M.D., Indiana State Board of of Health.

*Committee for the Study of Lay Activity in Medical Practice:*

*W. D. Gatch, M.D., Indianapolis, chairman.
*O. O. Alexander, M.D., Terre Haute.
Julia S. Thom, M.D., Spencer.
*A. E. Stinson, M.D., Rochester.
*F. A. Streck, M.D., Lawrenceburg.
*F. T. Romberger, M.D., Lafayette.
M. C. Pitkin, M.D., Martinsville.
Michael Shellhouse, M.D., Gary.
*G. O. Larson, M.D., LaPorte.

*Medical Relief Committee:*

*E. F. Boggs, M.D., Indianapolis, chairman.
*Joseph L. Allen, M.D., Greenfield.
James L. Wyatt, M.D., Fort Wayne.
*Claude S. Black, M.D., Warren.
*Alfred Ellison, M.D., South Bend.
Austin Sweet, M.D., Martinsville.
*K. L. Hull, M.D., Bloomfield.
*John D. VanNuys, M.D., Indianapolis.

*Council on Medical Service and Public Relations:*

*C. A. Nafe, M.D., Indianapolis, chairman.
*C. H. McCaskey, M.D., Indianapolis.
*N. K. Forster, M.D., Hammond.
*J. E. Ferrell, M.D., Fortville.
*F. T. Romberger, M.D., Lafayette.
*Norman M. Beatty, M.D., Indianapolis.
*J. William Wright, M.D., Indianapolis.
H. G. Hamer, M.D., Indianapolis.
*W. U. Kennedy, M.D., New Castle.
M. C. Topping, M.D., Terre Haute.
*W. H. Howard, M.D., Hammond.
*E. M. Shanklin, M.D., Hammond.
*Thomas A. Hendricks, Indianapolis.

**Membership Report**

| | |
|---|---|
| Number of members August 4, 1945 | 3,331* |
| Number of members August 4, 1944 | 3,330 |
| Gain over last year | 1 |
| Number of members December 31, 1944 | 3,400 |

*Includes 1,019 in military service and 140 honorary members.

The statements of receipts and expenditures for June and July for the association committees and THE JOURNAL were approved.

The compensatory increase in chest dimensions, whether in bronchial asthma or in cardiac failure, means one thing—insufficient oxygen.

In both types of condition, Searle Aminophyllin* is of value. It overcomes circulatory stasis by increasing the perfusion of the myocardium, and results in an improved heart action, an increased blood velocity and elimination of edema fluids by the renal route.

Both heart and lungs are thus enabled to function with decreased effort, and oxygen transmission is aided.

*Indications:*

**Cardiac decompensation**
**Bronchial asthma**
**Paroxysmal dyspnea**
**Aid in preventing anginal attacks**
**Selected cardiac cases**
**Cheyne-Stokes respiration**

*In all usual dosage forms*

G. D. SEARLE & CO., CHICAGO 80, ILLINOIS

*Contains at least 80% anhydrous theophyllin

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

**Treasurer's Office**

*Association bond.* Payment of premium on a three-year basis in order to save $99.60 was approved.

*Auditing Committee.* The treasurer reported that the Auditing Committee had met and had found everything in good order.

**Headquarters' Office**

Report made that Mr. Smith is serving as secretary of the Bureau of Publicity, at the suggestion of the executive secretary. This is done as the Publicity Bureau is launching an expanded program of activity.

**1945 Annual Session, French Lick, Tuesday, Wednesday and Thursday, October 2, 3 and 4, 1945**

*Postponement of session.* Motion made by Dr. Romberger, seconded by Dr. Ferrell, and carried, that the 1945 annual session be postponed, and that the House of Delegates meet subject to the call of the president. This meeting will be held in Indianapolis.

*Commercial exhibit.* It was suggested that a letter be written to those who have taken space in the commercial exhibit, saying that the meeting will be postponed because of transportation restrictions and that the state association will refund the initial payment or keep it as a reservation for the next session, the date of which will be set later.

**Legislative, Legal and Social Security Matters**

*National*

The attention of the committee was called to the analysis of the Wagner-Murray-Dingell Bill, *S. 1050* and *H. R. 3293*, by Wray Fleming, general counsel of the Hoosier State Press Association, Inc. The committee felt that this is as thorough, complete, and effective an analysis of the bill as has yet come to its attention.

Announcement made that Arthur J. Altmeyer had been reappointed head of the Social Security Board.

*S. 1318*, new maternal and child health bill, providing for an expenditure of $100,000,000 and free obstetrical and pediatric care by the Children's Bureau and the Department of Labor, introduced by Senator Claude Pepper and nine other senators, both Democrats and Republicans, brought to the attention of the committee.

*Meeting with American Farm Bureau Federation.* Report made that a special committee of the American Medical Association had met with the Health Committee of the American Farm Bureau Federation, and recommendations could be expected calling for joint meetings of the Indiana Farm Bureau group with the proper committees of the Indiana State Medical Association.

**Prepayment Medical Plans**

Announcement made by Dr. W. U. Kennedy, chairman, that the Committee on Prepayment of Medical and Surgical Care will meet at Indianapolis on September 9.

Inquiry from Dean Mitchell, president of the Indiana State Chamber of Commerce, in regard to the prepayment medical care program, brought to the attention of the committee.

**Organization Matters**

*Committee for the Study of Lay Activity in Medical Practice.* Dr. W. D. Gatch made a report on the meeting of his committee.

The creation of a Section on General Practice, which was recommended in the annual report of the committee last year and passed by the House of Delegates, was discussed. Dr. Forster is to name the officers for that section. Distinction was made between "Section on General Practice" and "Medical Section."

Monthly newsletter to be written by Ray Smith, to go to key committeemen and other committeemen, approved by the Executive Committee.

*Committee on Mental Health.* Dr. Forster moved that the Executive Committee approve in principle the speaking program arranged by the Committee on Mental Health, and that as soon as possible funds be made available for use of the committee. Motion seconded by Dr. Ferrell and carried.

Report made by Dr. Eugene F. Boggs, chairman of the Medical Relief Committee. This was supplemented by a statement by Dr. John D. VanNuys. The Medical Relief Committee requested that an advisory committee be appointed to assist Dr. Boggs' committee. This was taken under advisement.

Membership of a physician who has joined the United States Public Health Service, discussed by the Executive Committee. The committee was of the opinion that the rule concerning the membership of physicians in the employ of the United States Public Health Service could not be interpreted in any way that would allow this doctor membership gratis unless he is "assigned definitely to the Army or Navy."

Correspondence between Dr. Forster and the various committee chairmen relative to committee activities brought to the attention of the committee.

The committee approved the letter written by Dr. Forster to Dr. A. S. Brunk, president of the Michigan State Medical Society, in regard to the participation of Indiana in the panel program, but not in the radio program which was proposed at the Michigan meeting of seventeen presidents of state medical societies.

Dr. John D. VanNuys was appointed a member of the Medical Relief Committee.

Dr. J. V. Pace was appointed a member of the Anti-Tuberculosis Committee.

**State Board of Health**

*Advisory Health Council of the State Board of Health.* The committee expressed its appreciation to Governor Gates for his letter asking that the state medical association suggest names of physicians to serve on the Advisory Health Council. The committee felt, however, that, in accordance with the established rule, it should not recommend the name of any individual physician for membership on a governmental board, but that it would be pleased if the Governor checked with the association on the standing of physicians before they are appointed to the Advisory Council.

**War and Postwar Medicine**

Letters received from the Bureau of Information, of the American Medical Association, expressing appreciation to the state association for the material which had been sent to the Bureau of Information in regard to medical services in the various counties. The Indiana county survey is now completed, and a number of typical counties of Indiana were listed in the A. M. A. *Journal* of July 28, 1945.

Report that scores of responses were received from servicemen in regard to Indiana's request for the release of physicians from service who are not necessary to national security.

Correspondence of William Book, Indianapolis Chamber of Commerce, Congressman Louis Ludlow, and General George F. Lull brought to the attention of the committee. The committee recommended that this correspondence be carried in THE JOURNAL.

Letter received from Admiral Ross T. McIntire, in reply to the appeal for the release of physicians from the armed services, was carried in the August issue of THE JOURNAL.

**Rehabilitation**

Dr. John Hewitt and Dr. Carl D. Martz made a report in regard to the rehabilitation program which the advisory committee is submitting to the office of Clement T. Malan, state superintendent of public instruction. Dr. Martz discussed this program with the committee.

Letter in regard to radiological services and opposing the publication of any fee schedules discussed by Dr. Martz. Dr. Martz asked for the guidance and suggestions of the state medical association in this matter.

**Socialized Medicine**

Statement in *The International Teamster* entitled, "City Doctors Gang Up on Veterans," criticizing an

# J. E. HANGER CO.

## Artificial Limb Concern

## Celebrates 85th Anniversary

J. E. Hanger, Inc., manufacturers of artificial limbs, (Indianapolis office located at 1407 N. Illinois Street) recently participated in a nation-wide celebration of the eighty-fifth year of its founding and service to the armless and legless public. The present House of Hanger, including branches, subsidiaries, and licensed companies, is the largest manufacturer of artificial limbs in the world, with offices in twenty-five cities in the United States and Canada.

The business was established by J. E. Hanger on August 5, 1861. The youngest of five brothers, all of whom served in the Army of Northern Virginia at the outbreak of the war between the states, Mr. Hanger was an engineering student at Washington University, (now Washington and Lee) at Lexington, Virginia. He left school and enlisted in Stonewall Jackson's Brigade. He was severely wounded in battle, and is believed to have been the first man on either side to suffer an amputation.

With some education in engineering, Mr. Hanger made the first articulated artificial leg he ever saw. He carried on the business at Richmond until 1888 when he came to Washington. He invented a number of improvements during his lifetime, which are now generally used throughout the artificial-limb industry. He wore artificial limbs himself for almost three score years.

His six sons were brought up in the business, and when their training was completed the business began to grow, with branches, subsidiaries, or licensed companies now serving disabled veterans and civilians in all the United States, the Dominion of Canada, England, and France.

More than a quarter of a century ago the business was decentralized, largely to better serve wearers of artificial limbs in states remote from Washington. Many units of the business are separately organized, with no financial interest held by the Hanger family.

Two sons went to Europe in 1915 and established factories at London and Paris, with branches throughout England and France. Several years later Mr. Hanger, Senior, was personally commended by the late King George and Queen Mary for his work in rehabilitating British war amputees. The British Ministry of Pensions has contracted with J. E. Hanger & Co., Ltd., of London, for a term of years to supply permanent limbs to all British veterans and to maintain them at a minimum stated charge per year. With some variations, the same thing is true in France.

J. E. Hanger, Inc., has co-operated closely with the War and Navy Departments, and with the Veterans Administration, to afford the best possible service to Veterans of World War I and World War II.

An important improvement is the knee assembly designed by the Hanger organization, which is now being produced for all government contractors who are supplying above-knee temporary artificial legs to the seven amputation centers. J. E. Hanger, Inc., has been awarded contracts for socket patterns and master sockets to insure correct fitting of limbs at all amputation centers. The Hanger Company is also supplying, on contract with the Surgeon General, artificial legs for disarticulation of the hip, known as the Tilting Table leg. At the request of the Surgeon General the Hanger organization has trained, without profit, enlisted men and non-commissioned officers in order to qualify them to serve in government orthopedic shops.

The House of Hanger is vitally interested in the welfare of those in the Armed Forces, and they may well be, for three sons, a daughter, and five nephews of the Hanger family are in the service. Mr. Hanger states, "We are determined that there shall be no let-down in the quality of Hanger service to all Veterans, and that our past reputation for using only the best materials and workmanship shall continue. We are very proud of the fact that we have been commended by thousands of veterans who are wearing Hanger limbs."

**J. E. Hanger Artificial Limb Co., Inc.**

1407 N. Illinois St. LI. 4103

editorial which appeared in THE JOURNAL of the Indiana State Medical Association, brought to the attention of the committee.

#### Medical Economics

The committee discussed the offer of the State Chamber of Commerce to cooperate with the Indiana State Medical Association in making a survey of free medical and hospital services in Indiana. Ways and means of making this survey are to be discussed at the next meeting of the committee. The assistant secretary presented this matter to the committee.

*Death certificates and undertakers.* Dr. Leroy E. Burney, state health commissioner, discussed the complaints received from undertakers concerning the difficulty of obtaining physicians' signatures on death certificates. Dr. Burney is to prepare an article in regard to this, urging the doctors to cooperate, for THE JOURNAL.

There being no further business the meeting was adjourned.

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## INDIANA STATE MEDICAL ASSOCIATION

### BUREAU OF PUBLICITY

June 26, 1945.

Present: H. G. Hamer, M.D., chairman; B. B. Moore, M.D.; Mrs. Lotys Benning Stewart; J. R. Newcomb, M.D.; Ray E. Smith, assistant executive secretary, and Thomas A. Hendricks, executive secretary.

The following articles have been released to the newspapers since the annual report of the bureau:

"Tropical Diseases—Fungus Diseases."
"Tropical Diseases—Animal-borne."
"Tropical Diseases—Malaria."
Nine releases on Annual Session.
Three special releases to *Indianapolis Star, News,* and *Times.*
Three special releases to Press Associations, *Indianapolis Times, News, Star,* and Radio Editor.
One release on Secretaries' Conference.
Fourteen "Doctor Goodhealth" releases.
Special release on resolution passed by Executive Committee concerning release of doctors from armed services.

The bureau discussed the Wagner-Murray-Dingell Bill, *S. 1050* and *H. R. 3293*, and the preparation of material that might be used by speakers who would make talks before medical societies and the public on these measures.

#### Radio

(1) The script writer for the "Doctor Goodhealth" program and for other programs prepared by the Indiana State Medical Association discussed the subject of "radio" with the bureau.

(2) The national hook-up proposed by the Michigan State Medical Society for the seventeen states discussed by the bureau. The bureau agreed with the Executive Committee that before any funds could be allotted for such a project, this would have to come before the House of Delegates of the Indiana State Medical Association.

The script writer discussed the probability of a state hook-up and obtaining a commercial sponsor, and placing the Indiana State Medical Association on a commercial basis. A motion was made authorizing a survey of the possibilities of obtaining a tentative sponsor on a commercial basis so the state association program could go on the air at a better time.

### BUREAU OF PUBLICITY

July 9, 1945.

Present: H. G. Hamer, M.D., chairman; Mrs. Lotys Stewart, radio director; Thomas A. Hendricks, executive secretary, and Ray E. Smith, assistant executive secretary.

The radio director presented a letter which she had drafted for mailing to prospective sponsors of a new "Doctor Goodhealth" program. Contents of the letter were discussed, and it was turned over to the assistant secretary for revision along the lines of the discussion. The program will be presented, beginning in October, one night a week over an Indianapolis station, for a thirteen-week period under the sponsorship of firms whose products doctors use most, with those firms interested in the project sponsoring one or more programs in the series.

Report made that the July 9, 1945, news release of the bureau, entitled "Your Place in the Sun," had received unusually wide distribution and favorable comment.

The radio director read material she had prepared in regard to the Wagner-Murray-Dingell Bill. There was a discussion of the form to use in printing it. She reported that she would complete the copy within two weeks and again submit it to the bureau.

A letter from the chairman of the Committee on Mental Health of the state association was discussed. It was decided to ask the chairman of the Mental Health Committee to submit to the bureau a list of psychiatrists who would be willing to address various civic groups. Topics for discussion will be provided county medical society secretaries with the suggestion that speaking engagements be made for one or more of these speakers.

The assistant secretary offered two suggestions, as follows:

(a) That in the future weekly news release subjects be decided upon for a given period, and that this schedule then be followed.

(b) That a weekly column (suggested title, "Hints on Health") be offered to the 283 weekly papers of the state; the column to be sent to papers ordering it, and to be prepared with the help of physicians in certain fields of medicine.

Decision was made that the news release schedule be discussed with the radio director, who at that time had been excused from the meeting. The assistant secretary was instructed to prepare a suggested column for the weeklies, and to submit it to the bureau at its next meeting.

At the suggestion of the executive secretary, the assistant secretary was designated as bureau secretary for future meetings.

### BUREAU OF PUBLICITY

July 23, 1945.

Present: H. G. Hamer, M.D., chairman; Ben B. Moore, M.D.; Thomas A. Hendricks, executive secretary, and Ray E. Smith, assistant executive secretary.

The news releases entitled "Swimming," for release on July 30, 1945, and "Keeping Cool," for release August 6, 1945, were approved.

The assistant executive secretary suggested a weekly health column, entitled "Hints on Health," to be mailed exclusively to the weekly newspapers of the state who order it, the column to be offered in mimeograph form or entirely matted. Two sample columns were submitted to illustrate the nature of the feature. The committee considered a suggested letter to be mailed to editors of weekly papers, announcing the new column. After due consideration it was decided to try the column for the balance of the year, and the assistant secretary was instructed to proceed. The bureau went on record to credit the column to the "Bureau of Publicity" and not to "Dr. Goodhealth."

Material on the Wagner-Murray-Dingell Bill, prepared by the radio director, was studied and brought forth favorable comments.

The secretary reported that one favorable reply had been received to date in regard to the letter sent to exhibitors and advertisers informing them of the proposed paid "Dr. Goodhealth" radio program.

Program topics for 1945 and 1946, submitted by the program chairman of the Woman's Auxiliary to the Indiana State Medical Association, were discussed. The secretary suggested that the fourteen-point program of the American Medical Association should be included in the Woman's Auxiliary programs, and he was instructed to write the program chairman, complimenting her on the

*Uniform Satisfaction*

Schieffelin
BENZESTROL
(2, 4-di (p-hydroxyphenyl)-3-ethyl hexane)

Clinicians agree that Schieffelin BENZESTROL is a significant contribution to therapy in that it is both estrogenically effective and singularly well tolerated, whether administered orally or parenterally.

*"In our hands it has proved to be an effective estrogen when administered either orally or parenterally and much less toxic than diethylstilbestrol at the therapeutic levels"* (Talisman, M. R.—Am. Jour. Obstet. & Gynec. 46, 534, 1943)

*"During the last two years I have used the new synthetic estrogen Benzestrol in patients in whom estrogenic therapy was indicated. The results have been uniformly satisfactory"*. (Jaeger, A. S. Journal Indiana State Med. Assn. 37, 117, 1944)

Schieffelin BENZESTROL is indicated in all conditions for which estrogen therapy is ordinarily recommended and is available in tablets of 0.5, 1.0, 2.0 and 5.0 mg.; in solution in 10 cc. vials, 5 mg. per cc.; and vaginal tablets of 0.5 mg. strength.

*Literature and Sample on Request*

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## The Indiana University School of Medicine

### Bloomington and Indianapolis

**MATRICULATION** **September**

**MINIMUM ENTRANCE REQUIREMENTS OF SCHOOL OF MEDICINE**

Graduation from a commissioned high school or its equivalent, plus three years of collegiate work, which shall include General Chemistry, Qualitative Analysis, a course in Organic Chemistry including at least ninety hours of laboratory work, one year of Biology and Comparative Anatomy plus Embryology, (recommended), one year of Physics, English, and a fair reading knowledge of French or German.

**CLINICAL FACILITIES**

In hospitals, 1,222 beds, including the Robert W. Long Hospital, the James Whitcomb Riley Hospital for Children, the William H. Coleman Hospital for Women, and the new Clinical Building. In dispensaries, about 115,000 cases per year. In obstetrics, the service is so large that most students attend several times the number of cases required by State Boards. This school lays special emphasis on the daily clinical dispensary and ward work of the members of the Junior and Senior Classes.

**INTERNSHIPS**

More than sixty-five hospital appointments are open to graduates.

**FIFTH YEAR**

Beginning with the session 1909-1910 a fifth year was added to the curriculum, which until further notice will be optional.

**COMBINED ARTS-MEDICAL COURSE**

In addition to the regular medical courses referred to above, a combined Arts-Medical course is given in which the work for the degrees B.S. and M.D. may be completed in seven years, and the work for the degrees A.B. and M.D. in seven years.

**FOR FURTHER INFORMATION ADDRESS**

**The Indiana University School of Medicine**

**Either at BLOOMINGTON or INDIANAPOLIS**

# Fitful Blaze

● Unaccountable pain and tension . . . vasomotor disturbances . . . irregularity . . . mental depression—all contribute to the familiar menopausal picture. *A picture that flickers—like firelight on a wall—interrupting many a woman's life program at its busiest.*

● You have a dependable treatment for menopausal symptoms when you administer a dependable solution of estrogenic substances.

● For this delicate task, Solution of Estrogenic Substances, Smith-Dorsey, has won the confidence of many physicians. Smith-Dorsey Laboratories are fully equipped, carefully staffed, qualified to produce a medicinal of guaranteed purity and potency.

● With this product, you can help to steady many of those "fitful blazes."

SOLUTION OF

*Estrogenic Substances*

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*Supplied in 1 cc. ampuls and 10 cc. ampul vials representing potencies of 5,000, 10,000 and 20,000 international units per cc.*

THE SMITH-DORSEY COMPANY
LINCOLN • • • NEBRASKA

*Manufacturers of Pharmaceuticals to the Medical Profession Since 1908*

fine job she had done in drafting the program, and suggesting inclusion of the fourteen points.

Resolutions passed by the Committee on Mental Health of the Indiana State Medical Association were received. The secretary reported that the chairman of the committee had a list of fifteen psychiatrists who had consented to speak before civic groups. The secretary was instructed to notify secretaries of all county societies and urge that speaking engagements be arranged.

A letter received from Miss Ruth McNutt, librarian of the Indiana University Medical Center, concerning inadequate housing of archives of the Indiana State Medical Association, was read. This matter was to be referred to the historian of the association.

## BUREAU OF PUBLICITY

August 6, 1945

Present: H. G. Hamer, M.D., chairman; Thomas A. Hendricks, executive secretary; Ray E. Smith, assistant executive secretary and secretary of the bureau, and Mrs. Lotys Benning Stewart, radio director.

New releases and dates of release were approved, as follows:

"Exercise in Summertime," August 13, 1945.
"Sunstroke and Heat Exhaustion," August 20, 1945.
"Back to School," August 27, 1945.

The radio director suggested that future news releases deal with the subjects: accidents, common colds and the game of football. She was authorized to prepare such releases for consideration by the bureau at its next meeting.

The executive secretary reported that Clarence A. Jackson, executive vice-president of the Indiana State Chamber of Commerce, and Wray E. Fleming, general counsel of the Hoosier State Press Association, had been recommended to the Optimists Club as qualified speakers on the evils of socialized medicine. He suggested that Mr. Fleming be asked to speak on the Wagner-Murray-Dingell Bill because of his wide knowledge of the subject, in the event of requests for speakers.

The bureau secretary announced that sample columns of "Hints on Health" would be submitted to the weekly papers of the state within the next few days. The column will be supplied to papers who order it.

A suggestion from the president of the association that a small feature pointing out that there is no such thing as "Free Medicine" be sent to the papers was discussed. The consensus was that it was a good idea, but it would not be used by the papers except as a paid advertisement. Action was deferred until an advertising campaign was believed necessary to influence Congressional action on the Wagner-Murray-Dingell Bill. The thought was advanced that the "no free medicine" idea might be worked into editorials which papers would use.

The radio director reported that seven or eight programs of the proposed thirteen-program radio series had been spoken for by firms interested in sponsoring them. She gave details of a radio program entitled "Your Health," which is on the air under the sponsorship of an insurance company.

The bureau secretary revealed that the Woman's Auxiliary 1945-1946 program had been revised to include the fourteen-point program of the Council on Medical Service and Public Relations, of the American Medical Association.

The chairman reported on the size and condition of medical records owned by the association and now stored at the Indiana University Medical Center, which must be relocated. It was decided to find out whether fireproof cabinets could be purchased to store the records in state headquarters. Facilities at the state library were ordered checked by the bureau secretary. Letter was read from the chairman of the Committee on Necrology and History, suggesting use of the State Historical Library.

Letter from the chairman of the Committee on Mental Health, suggesting a meeting of the committee and

fourteen psychiatrists who have offered to fill speaking engagements, was read. The bureau decided to suggest that the meeting be held at 10:00 A.M., Sunday, September 9, at the Columbia Club, when the Executive Committee and several other committees will meet in separate sessions and a joint dinner session. The bureau secretary was directed to convey the suggestion to the chairman of the Committee on Mental Health.

Material prepared by the radio director, on the Wagner-Murray-Dingell Bill, was reviewed. A new lead was declared necessary. The material is to be brought up to date and considered at the next meeting.

Copies of the annual report of the bureau were distributed to members for reading and return to the headquarters' office with corrections or approval.

## Books

### BOOKS RECEIVED

**THE CARE OF THE NEUROSURGICAL PATIENT.** By Ernest Sachs, M.D., Professor of Clinical Neurological Surgery, Washington University School of Medicine, St. Louis. 268 pages with 177 illustrations. Cloth. Price $6.00. The C. V. Mosby Company, St. Louis, Missouri, 1945.

**A SYNOPSIS OF MEDICINE.** (Eighth Edition.) By Sir Letheby Tidy, M.D. Extra Physician to H.M. The King; Hon. Major General, lately Consulting Physician to the British Army. 1,215 pages. Cloth. Price $7.50. The Williams and Wilkins Company, Baltimore, 1945.

## INDIANA STATE BOARD OF HEALTH

### DIVISION OF COMMUNICABLE DISEASE CONTROL

**Monthly Report—July, 1945**

| *Diseases* | *July 1945* | *June 1945* | *May 1945* | *July 1944* | *July 1943* |
|---|---|---|---|---|---|
| Chickenpox | 55 | 162 | 219 | 20 | 21 |
| Measles | 39 | 145 | 157 | 52 | 344 |
| Scarlet Fever | 77 | 219 | 403 | 79 | 59 |
| Smallpox | 1 | 1 | 10 | 0 | 3 |
| Typhoid Fever | 6 | 10 | 3 | 18 | 24 |
| Whooping Cough | 127 | 103 | 72 | 105 | 310 |
| Diphtheria | 14 | 24 | 17 | 20 | 8 |
| Influenza | 6 | 23 | 26 | 18 | 19 |
| Pneumonia | 0 | 6 | 9 | 12 | 12 |
| Mumps | 58 | 186 | 237 | 31 | 44 |
| Poliomyelitis | 5 | 7 | 4 | 49 | 3 |
| Cerebrospinal Meningitis | 12 | 7 | 12 | 15 | 7 |
| Undulant Fever | 7 | 4 | 3 | 17 | 7 |
| Encephalitis, Lethargic | 1 | 0 | 0 | 0 | 0 |
| Erysipelas | 1 | 2 | 1 | 0 | 0 |
| Impetigo | 4 | 5 | 2 | 1 | 0 |
| Septic Sore Throat | 1 | 1 | 1 | 2 | 0 |
| Malaria — Acquired Outside U. S. | 3 | 3 | 0 | 4* | 12* |
| Rubella | 4 | 6 | 8 | 2 | 24 |
| Filariasis | 1 | 0 | 0 | 0 | 0 |
| Pink-Eye | 1 | 0 | 0 | 0 | 0 |
| Infectious Jaundice | 2 | 5 | 0 | 0 | 0 |
| Tuberculosis, Pulmonary | 185 | 285 | 167 | 241 | 218 |
| Tuberculosis, Other Forms | 11 | 12 | 10 | 6 | 42 |

* *Not classified as to whether the malaria was acquired inside or outside of the United States.*

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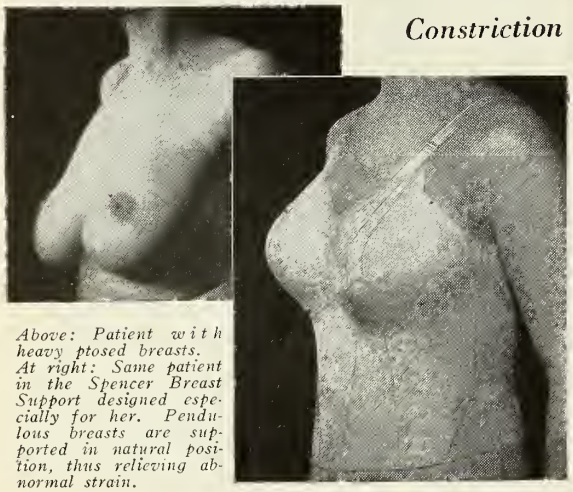

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## TECHNICAL INFORMATION FROM OFFICE OF SURGEON GENERAL

### STREPTOMYCIN BEING STUDIED

A new drug, streptomycin, companion to penicillin as a killer of bacteria, is being studied and undergoing tests by the Army Medical Department to determine its suitability as a germ killer in saving the lives of wounded and sick American soldiers.

The new drug shows possibilities which may prove to be as important to the medical profession as was the discovery of penicillin. Streptomycin is a killer of gram-negative bacteria, such as tuberculosis, cholera, dysentery, typhoid, tularemia, and salmonella food poisoning. Penicillin is a killer of gram-positive bacteria, such as pneumococcus, streptococcus, staphylococcus, gonococcus, and syphilis.

Even though the new drug is still in the laboratory stage, some is being produced and small quantities are being made available to the Medical Department for experimental purposes, according to Brigadier General Hugh J. Morgan, Chief Consultant in Medicine to Major General Norman T. Kirk, The Surgeon General.

Since streptomycin and penicillin resemble each other in many respects, General Morgan pointed out that experience gained in the production of penicillin will aid materially in the production of the new drug. The production process, however, is slow and tedious, and it will be some time before the drug is available in any quantity, he said—just as it took more than two years to bring penicillin into production for general use.

Dr. Selman A. Waksman, of the Department of Microbiology of the New Jersey Agriculture Experimental Station at Rutgers University, New Brunswick, New Jersey, is given credit for the discovery of streptomycin. Ever since the discovery of penicillin, Medical Department and civilian bacteriologists, as well as Army and commercial laboratories, have been searching for a drug that would fight the diseases that penicillin cannot cure. Dr. Waksman reported that he had discovered streptomycin and had reported on it some twenty-nine years ago during experiments with soil bacteria.

### PLASTIC ARTIFICIAL EYES

Thirty installations, twenty-nine general hospitals and one regional hospital, have been designated plastic eye centers for the Army Medical Department. "There is no existing backlog for plastic eyes and it is not contemplated that any more centers will be opened," said Major Trygve Gundersen, M.C., Chief Consultant in Opthalmology to Major General Norman T. Kirk, The Surgeon General.

All existing laboratories have adequate space, personnel, and supplies, with the exception of one general hospital, and action is being taken to expand the facilities so that production can be increased at this establishment.

As of June 30, 1945, approximately 5100 plastic artificial eyes have been made and fitted. In addition, the plastic eye laboratories have made conformers, eye spheres and other appliances for the eye clinics.

Experimental work is still being carried on in the plastic artificial eye program. Technicians are continually endeavoring to improve and give these plastic eyes greater mobility and lessen abrasion.

Three teams of officers and enlisted men who are experienced in making plastic artificial eyes are overseas, and four additional teams are now being trained in this work.

## ABSTRACT: FIGHT MOUTH CANCER THROUGH EDUCATION

Cancer of the mouth, which comprises 3 per cent of all cancer and accounts for 3,700 deaths annually in the United States, is easily accessible so far as treatment is concerned; yet the five-year survival rates are no better than for disease in some of the more inaccessible organs, such as the stomach and large intestine.

This conclusion was reached by Edwin A. Lawrence, M.D., and Philip S. Brezina, M.D., of New Haven, Connecticut, after studying one hundred forty-five consecutive cases of cancer of the oral cavity between January 1, 1931, and December 31, 1940, inclusive. Their report appears in the August 4 issue of *The Journal of the American Medical Association.*

The two authors, who are from the Department of Surgery of the Yale University School of Medicine, said that there was a widespread fatalistic tendency to give up in despair when such a disease is encountered. "We do not deny that these tumors are difficult to handle," they added, "but this does not justify pessimism and should stimulate greater efforts toward earlier diagnosis, more intensive therapy, and closer follow-up care."

It is generally considered, the two doctors said, that the five-year survival rate when cancer invades the lymph nodes or glands will be 50 per cent or less of that obtained when the lymph nodes are free of disease. The majority of the total group had lymph node involvement on admission to New Haven hospital or developed it at a later date, and only four of these survived five years.

Treatment of cancer anywhere in the mouth is essentially a radiologic problem, to be treated with radioactive substances or x-rays, since only a small number of cases are entirely suitable for surgery, the doctors said, pointing out that there were only three patients in a five-year survival group who were treated entirely with surgery. All of the others were treated with x-rays or with x-rays in combination with radium.

"There seem to have been several causes for failure," *The Journal article said.* "One of the most important is the frequency of lymph node involvement, which complicates the treatment program. Another was inability to control the primary lesion. The best results were obtained in the floor of the mouth, where the primary tumor was successfully and permanently controlled in 59 per cent of seventeen cases. The poorest results were in the palate, where only two, or 18 per cent, of eleven patients had permanent control of the primary tumor. The principal cause for this failure was inadequate therapy, both surgical and radiologic, in the early years of the study."

The authors said that another factor in the cause of failure is delay on the part of the patient in seeking treatment.

Surgery and x-ray radiation are the best methods for treatment. Until a new and better method is discovered, the doctors said, "attempts at improving our results must be directed not only toward the more intelligent use of these two instruments, but also toward making them more available to the general public and practicing physicians at large, and toward educating the public and physicians in the early signs and symptoms of this disease."

Referring to cancer of the mouth as a dental problem, the physician said:

"The same educational program must be intensified in the dental profession as well as in the medical profession. Thirty-seven of the patients in this series had been seen first by a dentist. Ten of the twenty-two in one group had been seen and treated by a dentist before being referred for medical care, and eight of these had delayed for more than two months.

"The signs and symptoms of early disease and the principles of adequate treatment must be emphasized in educating the public and in training physicians and dentists, if the survival rates are to be improved."


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OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 38 OCTOBER, 1945 NUMBER 10


## INDUSTRIAL HEALTH ACTIVITIES OF GOVERNMENT


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United States Public Health Service

BETHESDA, MARYLAND


Responsibility for the health protection of our army of industrial workers lies primarily upon industrial management, labor, and the medical profession itself, but our governments—federal, state, and local—share in this responsibility. Theirs is the task of stimulating and initiating work in industrial health, of carrying on the basic research and surveys out of which standards are formulated, and of investigating dangerous plant conditions and recommending remedial measures.

Many agencies of government are concerned with industrial health and safety. In the Federal Government are several agencies working in various phases of industrial hygiene. The United States Department of Labor, for instance, has its Division of Labor Standards, its Children's Bureau, Women's Bureau, and Bureau of Labor Statistics active in this field. The Bureau of Mines of the Department of the Interior is concerned with the health and safety of approximately a million workers in mining and allied industries.

But we shall speak here primarily of the United States Public Health Service, which for more than thirty years has taken a leading part in promoting industrial health in this nation. The Industrial Hygiene Division of the Bureau of State Services, and the Industrial Hygiene Research Laboratories of the National Institute of Health are the Public Health Service arms at present carrying on this work.

The original Office of Industrial Hygiene and Sanitation, of the Public Health Service, was established in 1914, and it may be credited with much of the fundamental research, both in the laboratory and in the field, out of which the science of industrial hygiene has developed. While considerable knowledge concerning industrial health hazards was gained in the years between 1914 and 1935, comparatively little was done by the government to apply this knowledge where the practical application must be made—in the factories and mills and plants throughout the nation.

The impetus to this practical application of industrial hygiene knowledge came from two sources: from passage of occupational disease compensation laws by an ever-growing number of states, and from passage of the Social Security Act, which provided funds for the development and extension of industrial hygiene along with other branches of public health work. The industrial physicians of Indiana know how important an occupational disease compensation law is to the establishment of good industrial health practices. Indiana's law, which provides general coverage compensating workers for a disease arising out of their employment, has given the necessary stimulus to employers to set up medical care programs and to utilize the services of industrial physicians and industrial hygienists.

### DEVELOPMENT OF INDUSTRIAL HYGIENE PROGRAM

Our concept of the meaning of industrial hygiene has undergone an evolutionary process, just as has the concept of industrial medicine. Not many years ago the industrial physician was concerned first and foremost with traumatic injury on the job. Now industrial medicine receives recognition as a specialty in its own right, requiring a great deal of knowledge of the materials and processes of industry and a high degree of special skill on the part of the physician practicing it. Similarly, industrial hygiene has evolved from a limited study of certain

existing industrial health hazards, with some attempt to control them by engineering means, into a science which seeks to understand, evaluate, and control all health risks to workers and to incorporate such controls into the processes of industry.

We share with the industrial branch of the medical profession our central objective—to cut down as far as possible the staggering amount of time lost from work because of illness and accidents by the industrial workers of this nation. Stated positively, the objectives of industrial hygiene are twofold: (1) To develop knowledge and methods which will protect every worker in industry and apply to every such worker all available public health knowledge, thereby assuring each as much complete physical and mental fitness as nature permits; and (2), to promote the adoption and practice of such health standards by the parties involved, that is, management, labor, the medical profession, and the official and non-official agencies giving health service to industry.

The governmental organization for translating these objectives into reality consists of the Public Health Service agencies for service and research already mentioned and, at the present time, of forty-nine official industrial hygiene units located in thirty-nine states. Most of these units are divisions of the state departments of health. Some are arms of city and county health departments. Two are divisions of state labor agencies.

In the Industrial Hygiene Division, functioning under the Chief of the Division, are the following sections and units: (1) The Field Operations Section, which provides administrative and other services to the states, supervises and encourages official industrial hygiene activities throughout the nation, trains industrial hygiene personnel, carries on workers' health education activities, and which during the war acted as a clearinghouse for all field activities protecting the health of war workers; (2) The Dermatoses Section, which carries on basic research and field investigations in industrial dermatoses, makes special studies and recommends suitable control measures when outbreaks of industrial dermatitis occur, and conducts training of physicians in industrial dermatoses through direct education and extensive publications; (3) The Medical Unit, which conducts epidemiological investigations in industry, and gives consultative services in the medical problems of industrial hygiene; (4) The Engineering Unit, which conducts special investigations, gives advice to states and other governmental agencies, and carries on fundamental research in the methods and equipment for environmental control of industrial health hazards; (5) The Dental Unit, which promotes industrial dentistry programs in the states and takes an active part in the development of industrial dentistry as a branch of the dental profession; (6) The Nursing Unit, which gives assistance and advice in the establishment and maintenance of industrial nursing programs in the states, and which is concerned with the formulation of standards of industrial nursing and the encouragement of educational facilities and professional organization for nurses in industry; (7) The Chemical Unit, which formulates laboratory procedures, gives advice and assistance to state chemical personnel, and performs chemical analyses when necessary to supplement state facilities; (8) The Statistical Unit, which carries on cooperative work with many groups and persons and gives consultation to industry, labor, official agencies, insurance companies, and others on statistical problems pertaining to industrial health, which makes studies of occupational illness among industrial workers, and conducts other phases of the gathering and dissemination of information about industrial morbidity upon the basis of which necessary work may be planned.

### WARTIME PROTECTION OF INDUSTRIAL HEALTH

A brief description of our wartime work will best illustrate the Division's activities. Industrial hygiene work was tremendously increased, both in amount and scope, by World War II. This Division carried major responsibility for protecting the health and thus maintaining the output of the nation's war workers. We worked toward this end in close cooperation with other federal agencies responsible for various phases of the war effort, with state and local governmental agencies, with industrial management, organized labor, voluntary health associations, private industrial health agencies, universities, and other research and educational institutions, and with individuals and agencies representing a wide variety of activities and interests pertaining to the health of industrial workers.

One highly important function of the Division was the protection of employee health in the plants producing munitions. Our industrial hygiene teams, made up of physicians, engineers, and chemists, kept close watch over conditions in government-owned, contractor-operated munitions plants, reporting regularly to the Safety and Security Division of the Office of the Chief of Ordnance, United States Army, and following up to see that recommendations for needed improvements actually were carried out. Extraordinary success was achieved in this program, with the Chief of Ordnance stating in his annual report for 1944-1945 that disability and death rates from toxic exposures in the manufacture of explosives had been lowered to a point far below anything previously known.

In cooperation with the Navy and the United States Maritime Commission, a study of the health of shipyard workers was made, to determine the effects of such occupations as welding. Thousands of workers in shipyards on the Atlantic, Pacific, and Gulf Coast were examined. Results of this survey are being analyzed and soon will be announced.

In cooperation with the War Manpower Commission, the Division undertook to protect the health of workers in certain critical war industries where labor turnover was high, partly because of health hazards. Thus, environmental surveys were made

of working conditions in 379 foundries and forges located in twenty-seven states, and assistance was given in controlling health hazards in fifty primary and secondary lead smelters located in twenty-two states. These surveys were conducted by the state industrial hygiene divisions in cooperation with the Public Health Service. Studies of the working conditions in certain chromate plants were made, at the request of the War Production Board, and extensive alterations were recommended in some plants to reduce the exposure of workers to chromate dust and mists. Under agreement with the War Production Board, investigations of industrial health conditions were made also in the aluminum reduction, asbestos textile, and other critical industries.

These are but a few examples of this kind of cooperative federal activity in the protection of the health of our workers. The Division cooperated with the industrial feeding program of the United States Department of Agriculture, to develop better facilities for on-the-job nutrition of war workers. Support and assistance were given to the United States Department of Labor in drives against health and safety hazards in such key industries as meat packing and slaughtering, paper and pulp manufacture, planing mills, and small wooden container manufacture. A drive has just been launched against accidents and illness in the fabricated steel industry.

### WARTIME RESEARCH

These and similar wartime activities in the field were supported by basic research carried on in the Industrial Hygiene Research Laboratories of the Public Health Service. Before Pearl Harbor our laboratories had begun investigations into the toxic properties of explosives. And so when intensive production of TNT, PETN, smokeless powder, double base powder, and other munitions of war was launched we had the knowledge upon which to base control measures. Our laboratories were called upon constantly by the Army and Navy to test new explosives and chemicals used by the armed forces in the various theatres of war. The health hazards in every step of the manufacture, as well as the handling and use of these substances, had to be understood. That amazing insecticide, DDT, had to be tested for its possible toxicity to human beings before the Army could release it for field use. A particularly interesting piece of research done for the Navy was the testing of new and non-inflammable battleship paints for toxic effects, since the Navy found early in the war that it must stop using the old battleship paints because of their high inflammability under battle conditions.

For the Army and Navy our laboratories had been conducting studies of high-altitude temperature and pressure effects upon flying personnel. They developed new oxygen-breathing equipment, and the oxygen-helium method for resuscitation. They had been studying effects of tropical conditions and acclimatization methods.

Extensive research was carried on in the toxicology of all types of organic and inorganic materials and compounds used by our war industries. The ingredients of synthetic rubber had been tested well before Pearl Harbor, in anticipation of the cutting off of our natural rubber supply. As the synthetic rubber industry was developed, therefore, it was possible to incorporate the necessary safeguards into plant construction, and to give the guidance necessary to protect the thousands of workers in this industry which mushroomed suddenly from nothing to become larger than our entire chemical industry before the war.

Not only national but international agencies received wartime cooperation from the Industrial Hygiene Division and the Industrial Hygiene Research Laboratory of the Public Health Service. We gave consultation and other assistance to the Pan-American Sanitary Bureau. We gave training in industrial hygiene to Latin-American physicians, engineers, and chemists, through arrangement with the Institute for Inter-American Affairs.

But perhaps the most dramatic part of the wartime story lies in the development and functioning of the federal-state-local cooperation in industrial health work.

### SERVICE TO THE STATES

The policy and approach of the Public Health Service in relation to industrial health problems always have been based upon the premise that, since corrective measures are accomplished with private effort and by private funds, the proper function of the official industrial hygiene agencies is to aid industry to solve its own health problems. When emergency funds became available, in 1941, the service undertook to develop and strengthen the work in the states, rather than to establish a strong industrial hygiene organization functioning through federal authority.

Before 1936, and the passage of the Social Security Act, only six states were carrying on active industrial hygiene programs. Appreciation of the necessity and worth of industrial health work has grown until today we find forty-nine official industrial hygiene units active in thirty-nine states, as agencies of state, city, and county governments and the Tennessee Valley Authority. In addition to their own professional and clerical employees, they have had the services, upon a loan basis, of about half the professional staff of the federal Industrial Hygiene Division. Until the end of the war at least half their working budget had been derived from federal funds. But now many state legislatures are giving better support to their industrial health agencies, and it is expected that the state programs will be expanded to meet post-war industry's health problems.

Some idea of the scope and complexity of their work may be obtained from an analysis made by this Division of the activities in the states for the two-year period from July, 1942, through June, 1944. In this time the state and local industrial hygiene units rendered some forty-two thousand services in the prevention and control of occupa-

tional-disease hazards to nearly twenty-four thousand industrial establishments, employing more than nine million workers. These services included a very large number of plant industrial hygiene surveys, tens of thousands of laboratory tests on materials used in industry, and thousands of medical examinations where occupational disease was suspected.

The Industrial Hygiene Division of the United States Public Health Service has aided this work not only with funds and trained personnel, but by every other means possible. Administrative and planning help is provided all units. A regular program of evaluation and guidance of the work in the states is carried on, with annual visits which are uniformly welcomed by the state directors. Engineering and laboratory equipment of particularly costly or specialized types are loaned to the state units as needed. Guidance and training of laboratory personnel are provided, and specimens are analyzed in our laboratories where the states lack the special equipment or personnel to perform necessary tests themselves. Consultative services are given on every phase of industrial hygiene by the Division's staff of specialists. Problems of engineering, industrial medicine, toxicology, dermatology, dentistry, nursing, and health education are met as they occur, and special studies and investigations are conducted by Division personnel at the request of the states. A constant stream of publications on all phases of industrial hygiene emanates from the Division, to bring to the state personnel and others working in industrial health the best new knowledge in this field.

### POSTWAR NEEDS AND PLANS

The strains and stresses of wartime manufacturing conditions proved the value and efficacy of industrial health activities to all parties concerned. Management is aware as never before that industrial health measures pay. Labor is becoming more and more conscious of health as an economic asset of workers, and as a result some unions are calling for health-protective clauses in union contracts.

Together, the private and governmental forces have built a firm foundation for the needed expansion of industrial health work to protect and advance the health of our vast labor force, comprising more than fifty-two million workers. But much remains to be done. And, because new problems have been created by the war and because technological advance itself confronts us with a vast complexity of new and possibly toxic materials and processes, we have many new problems to meet and solve.

One major, and basic, problem is the acute shortage of well-trained industrial health personnel. To meet this, we must develop adequate training facilities for industrial-hygiene people—physicians, engineers, chemists, nurses, dentists, and others.

But a great part of this shortage consists of the lack of properly-trained physicians and surgeons for industrial service. The policy of the Indiana State Medical Association, in providing training for private practitioners of the state, so that they may serve industry and industrial workers by knowing how to recognize and treat the diseases of occupation, may be expected to bear fruit in the reconversion period and beyond.

A survey made in 1939 showed that in Indiana only about 10 per cent of the state's labor force of nearly two million workers had the services of full-time physicians in their places of employment. Another 19 per cent had available the services of part-time physicians, and about thirty-six per cent worked in plants which employed full-time nurses. No doubt the war has changed this picture, but the problem remains substantially the same.

Since Indiana is not a state where large plants predominate, but rather one where the small industrial establishment is typical, the answer to this problem consists of working out a feasible plan or series of plans for providing effective part-time medical service to industry, of improving the general practitioner's knowledge of occupational diseases, and of strengthening and extending the official industrial hygiene work. Indiana's fine industrial hygiene service, now more than seven years old, last year cost the state approximately two cents per industrial worker in the state's population. A few serious cases of occupational disease can cost an employer more in compensation than was spent on the entire industrial hygiene program, which can prevent so much of the illness of workers.

Another important aspect of the post-war industrial hygiene plan is fundamental research. Many studies and investigations should be made in the engineering control of industrial hazards, by such means as the designing of effective ventilation for general and special purposes. A whole new field is opening up with the application of sight-conservation knowledge and measurements to industry.

The return of a great many handicapped war veterans makes urgent our need to devise scientific methods for the effective adjustment of the handicapped to industry. We are making a beginning in this task. In connection with interstate transporta-

*An interior view of one of Indiana's Industrial plants.*

tion, the Industrial Hygiene Division is working with the Interstate Commerce Commission in developing a method for utilizing the services of veterans as drivers, while safeguarding the public. We are also working on the development of what may be called the "psycho-physiology of occupation," that is, the definition of the physical and mental requirements of jobs and the establishment of norms and standards for employment. This work seeks to integrate the work of the industrial medical examiner, the psychologist, and the psychiatrist, so as to fit the job to the worker and the worker to the job. It opens up vistas of vastly improved efficiency in our industrial production.

We are carrying forward as rapidly as possible our studies in the dermatoses of industry. You probably already know of the results of one recent study, by which it was shown that the dermatophytosis which is so widespread is not significant as an industrial factor.

New industrial hygiene problems are being posed by industries, which will be prominent in the foreseeable postwar world. Air transport is one such industry. For war purposes, our laboratories had been studying the human factor in flight. Now, this and more aviation research must be applied to civilian air transport, to make available knowledge needed for the proper selection of flight personnel and to safeguard passengers and cargo. Air conditioning is another such industry. Atomic energy production is still another, and here you may be interested to learn that in the National Institute of Health studies are at present under way, utilizing several species of animals to learn the effects of neutron bombardment upon growth, reproduction, lactation, and other bodily processes.

As rapidly as they develop, we are analyzing new chemicals for their toxic potentialities and investigating new industrial processes for health hazards. We have just launched a study of the health hazards in the cemented tungsten carbide tool industry, which is sure to expand rapidly in this reconversion period. Some further examples are the new plastics, synthetic rubber, the fabrication and welding of various light and heavy metals, the rare metals such as beryllium, and the wide use of x-ray for industrial inspection. In this work our purpose is to anticipate the health problems of peacetime production. We want to have the fundamental research already done before new materials and processes get into widespread use, so that the necessary safeguards may be incorporated in the construction of industrial plants.

There are other aspects of industrial hygiene which remain to be properly developed. Industrial dentistry still needs to be made widely applicable. Mental hygiene should be placed at the service of management and workers on the broadest possible scale. Health education in industry has barely begun to demonstrate its potentially vast usefulness. The application of our knowledge of how to prevent or correct the multitude of non-occupational diseases and disabilities to our industrial population must be further intensified. Reliable data in the industrial health field are scant at present. We still have to develop effective reporting of occupational disease, and to carry forward the statistical compilation and analysis which are the necessary guides to effective industrial hygiene work.

All these and many other lines of research and activity represent the ways by which industrial hygiene can and should work in the service of the American people. A good share of this work, and its application in the industrial establishments of the nation, falls logically upon governmental agencies, along with the industrial health instrumentalities of management and labor, the insurance companies, and voluntary health groups active in this field. The cordial good will which has been the pattern of cooperation between the medical profession and official industrial hygiene agencies in the past no doubt will be even more in evidence as the service and value of industrial hygiene to the practicing physician become even greater.

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## ABSTRACT: PENICILLIN PRODUCES BEST RESULTS IN TREATMENT OF "TRENCH MOUTH"

Penicillin is playing an effective role today in the treatment of Vincent's angina, according to studies reported in the July 7 issue of "The Journal of the American Medical Association."

One physician, Captain Bernard M. Schwartz, of the Army Air Forces Regional Hospital, Truax Field, Madison, Wisconsin, said, after making a study on fourteen patients, that penicillin is "definitely superior" to the previous agents used in treatment.

"The rapidity with which penicillin acts," he said, "should be of value in reducing the loss of man-hours in military and civilian life, in decreasing contagiousness, and in reducing the period of discomfort for the patient."

The disease, which is caused by a peculiar spiral organism, was given the name "trench mouth" during the first World War because it spread so widely among the soldiers. Symptoms include pain on swallowing, enlargement of the glands, and a yellowish gray membrane in the mouth and throat.

Following his study, Captain Schwartz recommended a dosage of 100,000 units of penicillin injected into muscular tissue in 20,000 unit doses every three hours. Smaller or larger doses may be required, depending on the severity of the condition.

"The result in each case treated was satisfactory," Captain Schwartz said. "In every instance subjective discomfort was decidedly alleviated in twenty-four hours and completely eliminated in forty-eight hours. There was definite improvement within four to six hours."

Similar results were reported in another study by three physicians—Major Paul L. Shallenberger, Lieutenant Colonel Earl R. Denny and Major Harold D. Pyle, all of the Medical Corps, Army of the United States.

They used penicillin in a well-planned study on several different groups of patients admitted to the communicable disease section of the Gardiner General Hospital, in Chicago.

In their conclusions, the doctors state:

"The present clinical study demonstrates that penicillin is a remarkably effective agent in the treatment of Vincent's infection. A favorable response was obtained in all cases treated locally."

# THE WAR'S IMPACT AND INFLUENCE ON INDUSTRIAL MEDICINE

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World War II found industrial medicine ready. Its job, as in peacetime, was the maintenance of health, and for that no conversion was necessary. Of course, there was a shortage of experienced industrial physicians, but this was offset somewhat by the employment of a few additional practitioners, many nurses, and some lay technical aides. The Council on Industrial Health was instrumental in preparing the general practitioners for many of the problems which occurred in the smaller factories, and was responsible for promoting a bond of mutual understanding between the practitioners and the industrial physicians, which was helpful.

After December 7, 1941, the expansion of industry was beyond all comprehension, and in order to obtain the required number of workers practically every available citizen between the ages of eighteen and sixty-five, who was not in uniform, was hired. To the industrial physicians such expansion meant the examination of hundreds of new employees. Handicapped, and otherwise, they had to be appraised as to their mental and temperamental capacities as well as to their physical capabilities.

In its infancy industrial medicine was most directly concerned with the repair of occupational injuries; during the war this function was relatively subordinate to the duties of health maintenance. Besides the direct treatment of injuries, industrial physicians have given preplacement examinations to new employes and recommended placement according to the physical, mental, and temperamental capacities; have made periodic reexaminations; initiated health education programs; diagnosed and treated occupational diseases; treated emergency non-industrial ailments with their subsequent referral to private physicians; inspected sanitary facilities; inspected cafeterias and advised on well-balanced diets; and have directed the training of emergency first aid workers among plant personnel. On the whole, the wartime job was exceedingly well done, and certain important by-products have come out of it.

*Administration*

Because of the limited number of physicians available to industry and the consequent need of depending on nurses and lay technical assistants, industrial doctors have learned much about administration. They have learned to function on an "organize, deputize, and supervise" basis.

In some respects this proved to be advantageous, for it brought industrial medical service more nearly in line with other industrial practices and procedures. In one respect it may not prove to be so beneficial because too much delegation of medical functions to other than physicians may in the long run, if carried over into peacetime practice, result in a deterioration in the quality of the service. It will be the wise plant physician who will know where to draw the line after reconversion, when experienced doctors come back from the war and again become available.

*Job Analyses*

Prior to the war industrial physicians were supposed to know their plant processes so well that they could advise offhandedly on placement. The employment of handicapped and marginal people in large numbers required greater precision in determining placement, and that in turn resulted in a variety of selective placement procedures. Those were based on job analyses to determine physical requirements for efficient job performance, as well as examinations of the people to determine their physical, mental, and temperamental capacities, thus permitting the matching of employes and jobs. Such procedures have proved to be sufficiently effective, especially in the re-employment of veterans, to warrant the assumption that they will be continued and further developed after the war. If so, they will require increasingly more medical participation in employment routines and will necessitate also greater proficiency in methods of determining interests, aptitudes, and temperamental qualities of people seeking employment.

*Tuberculosis and Syphilis Control*

X-rays of the chest and serological tests became common in preplacement examinations, and mass health surveys of industrial groups became more popular. These case-finding programs contributed importantly to the general control of tuberculosis and syphilis during the war, and, although not directly a responsibility of industry, their benefits to employe and community health have been of such value as to give them a permanent place in industrial medical practice.

*Women in Industry*

Employment of greatly increased numbers of women during the war brought additional health problems to plant physicians, largely in connection with sickness absenteeism. But the doctors were able to handle them more or less routinely, and the net result has been merely an increase in the volume of medical department service. Now that the war is over many women can be expected to return to their homes or their former employment.

*Long Working Hours*

The custom of working long hours was followed only in the early months of the war. Industrial physicians were interested in the long work periods as a possible source of fatigue, and to some extent researches were undertaken. However, fatigue was and still is difficult to evaluate, and there was no outstanding progress toward a proved conconclusion. The general feeling among industrial physicians was, nevertheless, that excessively long hours contributed to absenteeism and impairment of efficiency.

Later, when three shift operations became common, consideration of fatigue moved into the background and problems of fitness for second- and third-shift employment came to the front, largely because of the ease with which certificates of unsuitability could be obtained. As a means of correcting that situation and promoting better understanding between plant physicians and general practitioners, some meetings of medical societies were held in the plants. As these enabled the general profession to obtain firsthand views of working conditions and the extent of industrial medical supervision, they proved to be desirable, and the custom seems likely to continue under the auspices of the Council on Industrial Health of the American Medical Association and local industrial health committees.

*Standing Orders for Nurses*

Industrial physicians, and more especially nurses, have long seen a need for standing orders, particularly for nurses employed in small plants having part-time or on-call medical service. Such orders were prepared by the Council on Industrial Health and published August 28, 1943. Since then they have been available in reprint form through the Council and have been widely distributed. Standing orders are important to proper medical service in small plants, particularly for the reason, among others, that they are a clear guide to judgment and assist nurses in deciding which cases may be treated by them, and how, and which should be referred to plant physicians or general practitioners.

*Dermatitis*

There is reason to believe that dermatitis was fairly well controlled by the doctors of the war industries although it did lead the occupational diseases in frequency of occurrence and time lost. Control measures throughout have been wholly conventional, continuing in the form of such expedients as protective clothing, gloves, creams, and facilities for cleansing, although perhaps a bit more sedulously applied. This is a field for fundamental researches: What gives skin its protective qualities? What changes take place in skin that fails to protect? And, what can be done to restore protective qualities?

*Repetitive Ailments*

Relatively newcomers among the occupational diseases were the myosites, tenosynovites, and kindred conditions caused by a constant repetition of movements in certain hand operations. These ailments have been partially controlled by suitable engineering changes in tools and their handles, keen judgment in the "hardening" of new employes, and by transfers to other jobs in obstinate cases.

*Treatment of Non-industrial Cases*

The shortage of private physicians made it necessary for industrial doctors to be doubly cautious against the indiscriminate care of non-industrial sicknesses and injuries. Frequently employees would claim it impossible to obtain the services of a physician, and, when true, it was exceedingly difficult for plant doctors to deny them attention. Furthermore, many physicians, extremely busy in their private practices, welcomed opportunities to delegate minor services to the plant doctors. It is hoped that the many well-intentioned efforts in this direction will not prove eventually to be a source of embarrassment when physicians become available in greater numbers for private practice. Generally speaking, they probably will not become so, for industrial physicians usually have handled such delicate matters with tact and skill; they have foreseen possible developments even more portentous—in the form of industrial clinics for the general care of employees, which possibility must be avoided.

*A Code of Ethics for Industrial Practice*

Dr. E. S. Jones, chairman of the Committee on Industrial Health, of the Indiana State Medical Association, published a code of ethics entitled, "Industrial Medicine in Action," in the August, 1944, issue of THE JOURNAL of the Indiana State Medical Association; an excellent contribution which should be read by all physicians, both in private and in industrial practice.

Dr. Jones covered the rights of industry to choose its own doctors for preplacement and other examinations, and the diagnosis and treatment of occupational diseases and injuries; to develop its own health supervisory programs; and to choose consultants for the care of occupational diseases and injuries. He defined the ethical method of referring patients to private practitioners for the care of nonoccupational sickness, and in the event of differences of opinion suggests proper methods for consultation between private practitioners and industrial physicians. He also set up a procedure for reviewing expert medical testimony by county medical societies. The publication of this code of ethics has been a significant development in industrial medicine.

*Periodic Examinations*

Under the pressure of preplacement examinations of large numbers of new employees, and other more urgent medical department services, periodic health examinations have admittedly been relegated to less crowded moments, which rarely have occurred. Now comes the changeover with its layoffs and an easing of the pressure on the plant physicians. It is expected that periodic examinations will be

restored to full effect with the reconversion, for both management and employees want them.

*Inspection of Cafeterias*

Although plant cafeterias have not been a development of the war, their use has been greatly extended in the war industries, and plant physicians have seen the importance of routinely inspecting them and examining the attendants. The doctors have known full well that improper food handling, dish washing, and refrigeration are always potential sources of veritable explosions of enteric disease. Such prevention has been the heavy responsibility of plant physicians. Although most doctors have readily admitted that they are not dietitians, their knowledge of nutrition and the deficiency diseases has been a definite spur to cafeteria management in planning balanced meals. Sanitary inspection of plant cafeterias will continue.

*Health Education*

Methods of disseminating health information among industrial groups have varied greatly. Industrial physicians have realized its importance, but they have been too engrossed otherwise to give it very much attention, so health education has not progressed as an industrial medical activity during the war.

In the meanwhile, the nation has become health conscious, and there is a general demand for information of that nature. The public is getting it through popular magazines, newspapers, over the radio, and from other not too authentic sources. Industrial physicians are not, unfortunately, publicists, and it is difficult for them to devise and promote good mass methods. On the other hand, they have been responding to individual requests for health information from thousands of perturbed war workers, and in doing so they have as a group accomplished much in health education. That counselor service, as it has been known, is greatly valued by industrial management, as well as by the workers, and it certainly will become increasingly important in its influence on industrial health.

*Management Health*

The strain on industrial management was terrific during the war. The reasons were obvious to everybody, but more especially to industrial physicians, and they were concerned because they saw results which varied from minor breakdowns to total disabilities. Considerable attention was therefore given to management health, especially in the latter part of the war, and various plans were developed in its behalf. Generally speaking, they provided for rather complete diagnostic health examinations of the higher executives and key men, with explicit advice on how to prevent and overcome impairments of health without too much disturbance of normal life and industrial usefulness. That move has been extremely significant, for it has been, and no doubt will continue to be, of influence in creating proper attitude on health among industrial leaders and in fostering the conception of positive health and its maintenance, which has been so well expressed by Raymond Hussey, dean of the School of Occupational Health, Wayne University.

*Industrial Hygiene*

The control of occupational diseases during the war was so outstanding that industrial hygiene engineering established its position for all time. Although industry itself, because of the shortage of trained personnel, was forced to depend largely upon the official agencies, ably promoted by the Division of Industrial Hygiene, of the United States Public Health Service, it is reasonable to assume that industry will proceed to install its own industrial hygiene laboratories as soon as reconversion and availability of trained personnel permit.

*Return of Veterans*

Experiences with the veterans who have returned to employment thus far are proving the value of selective methods of placement, and with the use of those methods industrial physicians are finding that the veterans' problems are not of the magnitude they were at first thought to be. As this is written, experiences with a considerable number indicate that the per cent of those who require special consideration is relatively low—less than 10 per cent. On the whole, the veterans are now being recognized as normal people coming back from a tough job, and their return to civilian employment is becoming much smoother; nevertheless, it is fortunate that selective placement procedures are available and in use.

*Mental Health*

Industry has become interested in the methods of the Army Air Forces for selecting men who were capable of learning the techniques and withstanding the physical and emotional strains of combat flying. Although combat flying and civilian employment are not remotely comparable, the personnel procedures (for maintenance of morale as well as selection) are now recognized as the same in principle, differing only in the extent necessary to practical application in industry.

Insofar as the methods for determining mental and physical fitness are concerned, industry has made some very real progress during the war, but not so much in methods for determining temperamental fitness, and those are now beginning to loom large on the personnel horizon of industry. Industrial physicians have been more or less indifferent about the development, and in the absence of their leadership industrial psychologists have been taking over, with aptitude testing as their spearhead.

For the reason that the physical and temperamental qualities of people are closely related and interdependent, medical leadership would appear to be desirable if not essential. It is true that the sudden ending of the war may cool industry's interest in this only slightly-plowed area of per-

sonnel management, yet further studies of human relations in industry (humanics) may be expected. Physicians in industry, whether or not it is realized, are positively concerned with the mental health of the employees, and they should be influential in guiding any developments of that character that might come out of the war.

*Training of Industrial Physicians*

Experiences in the war industries have exploded the idea that any doctor can be an industrial physician without special preparation and training. Consequently, industrial management now wants doctors with the "know-how" to direct the health maintenance programs of their reconverted industries. In the latter days of the war several schools and universities laid plans for graduate instruction in industrial health; and it appears now that substantial progress may be made in that direction. This, of course, is fundamental to good industrial health practices.

*And Finally*

The war has produced opportunities for industrial physicians to improve their professional, industrial, and economic positions, and in doing so they have aided the entire medical profession to improve its public relations. Their ability to maintain the war gains during and after the reconversion will depend, of course, chiefly upon the industrial doctors themselves, but to no small degree will it also depend upon the intelligent and helpful interest of such organizations as the Indiana State Medical Association and its members.

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# INDUSTRIAL DENTISTRY

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Dentistry in industrial health programs, initiated in the critical production period during World War I, lapsed during the depression years. A similar production crisis in World War II saw the rebirth of dentistry in the industrial health and safety programs that were being adjusted and extended to meet changing war conditions. It was felt that since accidents and illness affecting oral conditions do not differ essentially from those attacking other parts of the body, dentistry, performing the same types of service rendered by industrial medicine, should be a part of industrial health programs. These dental services should include oral examination and diagnosis, emergency treatment with referral for complete service, adequate recording of findings and recommendations, and dental health education. Isolated plants, far removed from private dental practitioners, may find it necessary to increase the scope of these dental services, but in any case the services rendered should be available to all workers in the plant and supplied on the same basis as other industrial health services.

A pattern for the development of industrial dentistry was formed by the American Dental Association in 1941, when its House of Delegates adopted a resolution embodying minimum standards for industrial dental practice.[1] In 1943 the Association's Council on Dental Health included a committee on industrial health in its organization chart, and recommended that state councils on dental health follow this procedure. Many state dental societies have followed the recommendation, and now dental groups are available for consultation on industrial dental practice.

The Industrial Hygiene Division, United States Public Health Service, among other duties, acts as consultant to state health departments on questions of industrial health. Since May, 1942, the Dental Unit of this Division has worked with industrial hygiene divisions and dental divisions in state health departments, assisting them to correlate their activities and interests with those of the dentists and of industry, for the purpose of developing industrial dental programs as well as investigating industrial health problems that have dental implications.

FIGURE I

*Small industry dispensary providing dental examination services.*

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* From the Industrial Hygiene Division, Bureau of State Services, United States Public Health Service, Bethesda 14, Maryland.

[1] Committee on Economics, American Dental Association: Dental Service in Industry, *J. Am. Dental Assn.*, **29**:299, (February) 1942.

In the state health departments of three highly-industrialized states—Illinois, Pennsylvania, and Michigan—dentists are employed, full-time or part-time, promoting dental services in industry. In addition to the promotional work, studies on proper examination procedures and on the diagnosis of oral manifestation of occupational disease have been undertaken. In one study, bitewing x-rays for screening purposes were taken of all workers in the plants of several types of industry. This same group received a clinical oral examination with an explorer and mouth mirror. Since time is an economic factor in conducting physicial examinations, this study demonstrated that a clinical oral examination with a mouth mirror and explorer, and two bitewing x-rays, can be completed on an individual in five to six minutes. Industry feels that this amount of time expended on an oral examination can well be added to the time now allotted to the initial physical check-up of applicants for jobs.

Industrial diseases, while they may affect the teeth, are more likely to be reflected in other tissues and structures in the oral cavity. Lesions found in the mouth may be the first warning of a toxic exposure which, if discovered early, can be controlled by the industrial hygiene engineer. The following example illustrates this point: mercury vapor exposure manifests itself by certain systemic signs, although in the past mercurial stomatitis, the oral lesions of toxic exposure, has not been considered one of the initial manifestations. However, in a plant using metallic mercury in the manufacture of electric batteries, mercury vapor concentrations far above permissible limits were recently discovered and controlled, because a large percentage of workers on one of the plant operations complained of sore gums. Other clinical diagnostic signs of mercury poisoning were not in evidence at the time.

The dentist who specializes in industrial work must have a larger area of education and experience than is received in the dental school and in the general practice of dentistry. He should know the physical and toxic hazards to which the workers under his scrutiny are exposed, and how those hazards may affect the oral tissues. He must keep complete records of the worker's preplacement and subsequent periodic oral examinations. He must be able to correlate the oral findings with the general health picture. Is that worker's gingivitis caused by poor oral hygiene, by a blood dyscrasia, or is it caused by exposure to toxic materials in the working environment? Is it aggravated by salivary calculus, or are those deposits on the teeth the result of mouth breathing in a dusty atmosphere? A good oral examination and the early diagnosis of oral pathosis may be the means of controlling conditions that, if unchecked, would become disabling. In this way the medical and dental departments will work hand in hand, and the physician can be assured that oral pathosis will not complicate the medical picture.

An industrial dentist may acquire knowledge of industrial procedures, toxic materials, and the relationship of oral pathosis to conditions in the working environment in two ways, and find that an understanding of public health principles is necessary in either case. He may learn through practical experience by working in industry and associating with industrial physicians and engineers, or he may choose to attend courses designed for instruction in industrial hygiene and industrial dentistry.

Such a course of five days' duration was given at the DeLamar Institute of Public Health, Columbia University, College of Physicians and Surgeons, in December, 1944. The lectures in this course were given by nationally-known specialists covering the several subjects that make up industrial hygiene, as well as dental subjects of special application to the relationship of oralogy to conditions in industrial work. The various types of dental programs in industry were enumerated and discussed.

A survey of the presently operating programs in industry discloses their variety and emphasizes the value of industrial dental programs having one common denominator—*the essential dental services to be rendered.*[2] Once these essential services are assured, the operation of the program can be tailor-made to fit the plant and the plant's policy. For example, if we assume the essential services for all employees to be oral examination and diagnosis; emergency treatment and referral for complete dental service; adequate recording of findings and recommendations; and dental health education; then the minimum and maximum operation of these four essential services becomes a matter of definition by the plant to suit local conditions.

Thus, the minimum operation of these four essential services in a small plant could be conducted by a private dental practitioner "on call" for that purpose. This dentist can make oral examinations and render emergency treatment for the employees either at the factory or in his office. Dental health information can also be dispensed, not only through the usual techniques employed for group education, such as poster, pamphlets, and talks, but also by that most valuable method—personal instruction. The worker, during his oral examination, can be shown not hypothetical dental ills, but his own dental and oral defects. Emphasizing the danger to him if he neglects their correction will have a personal appeal. Dental health education can well follow this pattern in all programs of industrial dentistry.

A plant employing workers in numbers great enough to make it economically sound to engage

[2] Gafafer, W. M., ed.: *Manual of Industrial Hygiene and Medical Services in War Industries,* Division of Industrial Hygiene, National Institute of Health, United States Public Health Service, Chap. 6, L. D. Heacock: Dental Services. W. B. Saunders Company, Philadelphia, 1943.

the full-time or part-time services of one or more dentists should do so, for the proper functioning of an industrial dental program as an integral part of industrial health services should consume all or the major portion of the dentist's time and thought. The workers in the plant are his charge, and he, as a specialist, must make every effort to see that pathosis in the oral structures does not affect their work, and that their dental and oral health is not affected by the working environment.

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# PROGRESS IN INDUSTRIAL DERMATOLOGY

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An evaluation of the advances in any medical specialty depends on the criteria used. It is not the purpose of this presentation to evaluate or pass judgment on individual contributions to the field of industrial dermatology, brilliant though some of them have been, but to consider the progress that has been made from a broader viewpoint.

**Is industrial dermatology a specialty within a specialty?**

No one acquainted with the field of industrial medicine will fail to recognize the economic importance of the industrial dermatoses. The Dermatoses Section of the Industrial Hygiene Division of the United States Public Health Service, and the Committee on Occupational Dermatoses of the American Medical Association have pointed out that the over-all incidence of occupational dermatoses in the United States prior to the war was approximately 1 per cent of employed workers. In some of the war industries the incidence among new employees was on occasions as high as 50 per cent.

In an analysis of more than 32,000 cases reported among workers in seven states during the period of July, 1938, to October, 1943, plus the 9,116 cases previously reported, Brinton and Schwartz were able to show that petroleum products and greases, alkalis, and solvents were mainly responsible for the cases of dermatitis. The chief causes of industrial dermatoses, as well as the over-all incidence of industrial dermatoses, has remained relatively unchanged in the last five years—this, in spite of the research both in the etiology and prevention of industrial skin diseases which has been carried on.

The first step to any approach to a clinical pathologic process is an attempt at diagnosis. It is readily recognized that in many instances only a dermatologist can differentiate between an industrial and a non-industrial dermatitis. Once such a differentiation is made it is well to consider—is the well-trained dermatologist, unacquainted with industry, capable of determining the etiology of an industrial dermatitis and make suggestions for prevention? The problem often narrows itself down to the knowledge of not only industrial irritants as a whole, but the particular industrial environment of the patient in question.

The author has had a unique opportunity to evaluate the previous question. After being in general dermatologic practice for almost twenty years, he was suddenly thrust into the field of industrial medicine by being called into active service by the United States Public Health Service and receiving an assignment to the staff of the Dermatoses Section of the Industrial Hygiene Division. Three years of work in that office has convinced me that ordinary dermatologic training and experience needs to be supplemented by field work in industrial plants to properly evaluate etiology of industrial dermatoses, and to suggest practical preventive measures.

It is almost impossible to determine the exact cause of an industrial dermatitis without a thorough knowledge of the industrial environment of the worker. The mechanism of causation not only depends on what irritant is contacted, but often on how it is contacted. Certainly no broad rules for prevention and treatment can be laid down for future guidance of the plant management without such a thorough knowledge of the industrial exposure.

This clearly suggests the necessity for the dermatologist interested in industrial medicine to supplement his training by a course of study embracing common industrial irritants, their effects on the skin, and the general health; the method used in tracing the etiology of industrial skin diseases; the proper application of preventive measures; and field studies in manufacturing plants, et cetera. The practice of industrial dermatology is truly a specialty within a specialty. This is especially true if such a specialty embraced not only the treatment of individual industrial dermatologic patients, but the solution of the causes of outbreaks of industrial dermatitis; and the development of specific and broad rules for prevention as well as research in this field.

The greatest progress in the field of industrial dermatology is the recognition by the proper authorities of the importance of the industrial dermatologic field, and by the realization of the dermatologists of the necessity for supplemental training,

as has been previously discussed for them, to adequately cope with industrial dermatologic problems.

**Teaching of industrial dermatology.**

The proper place for training the industrial dermatologic specialist is in the postgraduate school. Only a bare introduction to this subject can be given to medical students. Special courses can be given to dermatologists who wish to interest themselves in this field, and to the regularly-enrolled postgraduate students who are seeking to become qualified as recognized specialists by following a prescribed period of study for two to three years. In addition, the field studies may consist of conducted tours, or better yet, actual externships in large industrial plants. Perhaps eventually cooperation with state industrial hygiene units might furnish the necessary field work.

Important as the training of such specialists would be, they will be small in number at least for the next few years. As such men are trained they could in turn serve as teachers for other groups. It might be worth while for medical schools to see that some member of their teaching staff is given the opportunity to acquire such special training.

The most important problem is to find some means of disseminating the accumulation of data, in a practical way, to the industrial physician and to the dermatologist who cannot take the time for too long a period of training. A very good beginning has been made by Dr. Louis Schwartz and his associates, of the United States Public Health Service, in the type of courses which they have been giving in the last three years in various sections of the country.

These courses have been thoroughly prepared, and they have in several instances consisted of courses of lectures and visits to industrial plants. The main criticism against these courses was that they were too concentrated. Even trained dermatologists and experienced industrial physicians had difficulty in digesting a portion of the material which was presented. Also, only a few men could devote two whole weeks, which was the minimum time in which such an amount of material could be presented. Such seminars are better given over a period of months, at convenient times, so that larger audiences could be reached.

Perhaps the most valuable contribution of these courses was to crystalize, in the minds of those who participated, the fact that here was a field which required a vast background of industrial experience to truly become qualified as an expert.

In discussing methods of dissemination of knowledge in this field, the ultimate beneficiary, the worker, cannot be neglected. Courses of lectures planned to acquaint industrial nurses and nonmedical personnel, such as safety men and the workers themselves, should be given. It is very important to acquaint the worker with the facts which he has to know to safeguard himself against industrial irritants. It has been my experience that it is much easier to obtain the cooperation of the workers in programs for prevention if they receive an explanation of why certain rules and regulations must be followed.

Frequently programs for prevention have proved inadequate not because the methods advocated were faulty, but because the mechanics of their application were not carried out properly.

**Research.**

Considering the economic importance of the industrial dermatoses, there is relatively little organized research being carried out in this field. There is not enough support by those who should be interested. Large industrial organizations and insurance companies should be leaders in urging that research in the field of industrial dermatology be carried out, and give financial support for such work. Even the Federal Government, under the pressure of war necessity, spent only a relatively small amount of money for this type of research. It seems that even this support by the Federal Government will cease or be markedly reduced now that peace has come.

More basic data is needed before progress can be made on the etiology of many of our industrial dermatoses. Let me cite an outstanding example, such as oil folliculitis. Here we have one of the most common industrial dermatoses. It is well known that certain elements in insoluble cutting oils are mainly responsible for the skin irritation. We also know something about its prevention. Yet statistics have shown that the incidence of cutting-oil dermatitis is still very high among exposed workers.

Whether the fault lies with the suggested preventive measures, or the fact that the workers do not adequately avail themselves of the protection given them, certainly the problem of cutting-oil dermatitis has not been solved. Should there not be support from industry and the interested agencies in a properly-planned research program to obtain a more basic knowledge of the factors involved? Perhaps a cooperative program of research between the engineer, the chemist, and the dermatologist could result in eliminating the factors largely responsible for a cutting oil dermatitis. In this way, in spite of carelessness on the part of the worker, basic causes for the dermatitis might be eliminated.

**Dermatologic problems in small plants.**

It is not the large manufacturing plant with its well-organized full-time medical staff which fails to keep abreast of advances in industrial dermatology. New data concerning etiology and prevention is quickly assimilated by such organizations and incorporated in their routine methods for prevention. However, the bulk of our industrial population is still in the small plant, many of them without a full-time physician or a physician who is

unacquainted with dermatologic thinking along industrial lines.

How is the worker in such plants to be reached? The burden of such dissemination of knowledge has been placed on state, county, and city industrial hygiene units and on federal agencies. In most states there is not enough properly-trained personnel as far as dermatology is concerned to begin to meet the needs of their industries. Certainly, there are not enough dermatologists attached to such units to make routine visits at frequent enough intervals, not only to trace the etiologic factors causing dermatitis, but, what is more important, to see that preventive measures are properly carried out.

It is not very likely that enough trained dermatologists will be available in the near future to properly staff such state units. However, such additions to the staff of the industrial hygiene division should at least be attempted in our larger centers.

Medical schools could actively participate in a service to small plants with members of their teaching staff and postgraduate students receiving a training in industrial dermatology. There is no reason why such a service could not be self-supporting.

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# EVANSVILLE INDUSTRIAL X-RAY SURVEY

PAUL D. CRIMM, M.D.

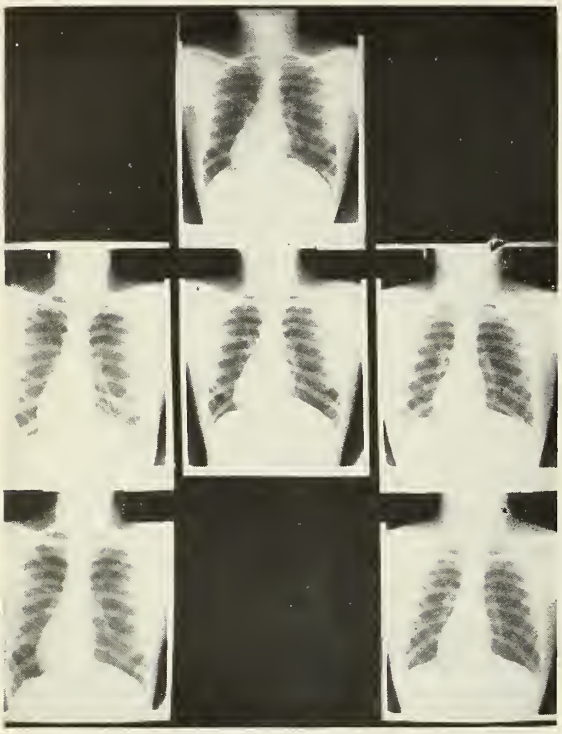
EVANSVILLE

In July, 1944, a Mobile X-ray Unit was purchased by the Vanderburgh County Tuberculosis Association for the purpose of finding open cases of pulmonary tuberculosis among the industrial employees of Evansville and vicinity. This association was the first organization in Indiana to own and operate a Mobile Unit. As soon as the purchase of this unit was sanctioned by the Vanderburgh County Medical Society, an X-ray Committee of the Tuberculosis Association was appointed to sell the project and operate the unit.

Both management and labor welcomed this survey as a means of ascertaining the health of employees, as far as their lungs were concerned. They realized that this survey would aid in protecting the health of employees who do not have active tuberculosis, but who might become infected while working with an individual who has active tuberculosis. If one does not know who has active tuberculosis in the industrial plant, in the movie house, in the school room, or in the church, he or she cannot employ the necessary precautions to prevent infection. One contracts tuberculosis from the unknown case, not the known case of tuberculosis who is already quarantined in the sanatorium or hospital. Early discovery of tuberculosis means, as a rule, early recovery of the active case, providing one stops work and goes to bed. The longer one delays going to bed, the longer the period of treatment and bed rest. The longer one delays quarantining himself, the more co-workers become infected with tuberculosis. In the State of Indiana there is a rigid quarantine law which assists the hesitating patient who is infectious to make up his mind about residing in a sanatorium.

During this x-ray survey any person who was suspected of having active tuberculosis was advised thereof, confidentially, by the Tuberculosis Association. Many who were ill appreciated this information and cooperated with their family physicians, but the proverbial few had to be followed up by the public health authorities. Management knew nothing about the employee's x-ray until he went to bed, when either insurance papers or plant assistance or counsel was required. Those individuals whose chest x-rays divulged healed secondary lesions of tuberculosis were advised to have a subsequent check-up at a later date. Those whose x-rays showed some abnormalities about their lungs, heart, or chest in general were advised to consult their family physician. Those individuals whose x-rays were negative, or had primary calcifications, were satisfied that there was no immediate danger. One should be mindful of the fact that anyone with a negative x-ray might contact an open case of tuberculosis and become infected, or, if an arrested case of tuberculosis, might break down his old lesions. Some of those individuals who were negative for tuberculosis by x-ray may harbor an invisible infection of tuberculosis. This tuberculosis may be hidden, for example, behind the heart, or in the abdomen, and cannot be demonstrated by radiograph, but it can be disclosed by a positive tuberculin test. Fortunately, most tuberculosis of the infectious type is located in the lungs, and a radiograph gives us an immediate answer. At the present time we are not using the tuberculin test, because we have found x-ray interpretation capable of advising, if necessary, further clinical and laboratory investigation. The tuberculin test, of course, reveals tuberculosis, active or arrested, anywhere in the body, in the majority of cases. If one does have a positive tuberculin test and a negative x-ray, he is reasonably safe. One safety factor lies in the fact that many people are positive to diagnostic doses of tuberculin, but few of them die from tuberculosis. Again, mortality statistics show that most of the deaths from tuberculosis are due to disease in the lung. Therefore, in a mass survey, why worry the average person with a tuberculin

FIGURE I



*Three 4 x 10 radiographs showing normal lung markings.*

test, and if positive with a follow-up x-ray, when a small x-ray film alone can speedily quiet his consumptive apprehensions?

### RESULTS

This report analyzes the findings of 20,000 industrial x-rays, taken over a period of twelve months. Of the 20,000 individuals, 14,162, or 70.8 per cent, were negative for pulmonary tuberculosis. Figure I shows three normal radiographs 4 x 10 inch. Forty-five hundred, or 22.5 per cent, had primary tuberculosis or first infection type, while 1,338, or 6.7 per cent, had secondary pulmonary tuberculosis, or reinfection type (Charts I and II). Twenty-two active cases of reinfection tuberculosis were discovered, or 1.1 active cases per 1,000 individuals. Figure II shows nine radiographs 4 x 5 inch, of far-advanced tuberculosis. During the period of the survey an additional eighteen active cases were found in industry through other sources, which makes forty active cases, or 2.0 per 1,000 (Table I).

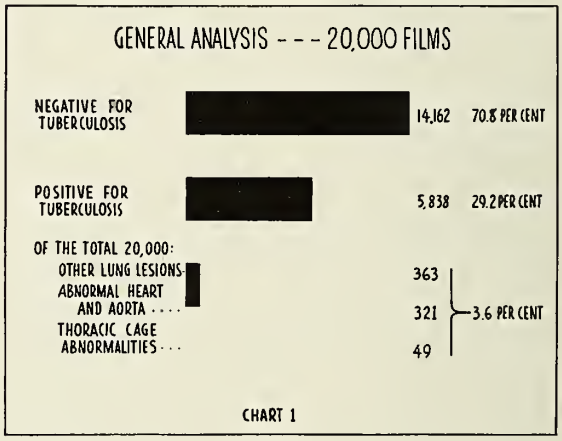
A stereoscopic film, 4 x 10 inch, was made of each individual, instead of a single 4 x 5 inch flat film. Although a stereoscopic x-ray doubled the exposures to 40,000, it increased the diagnostic efficiency of the radiograph, as proved by the fact that out of the 20,000 films only 147, or 0.7 per cent, required 14 x 17 inch stereoscopic films. The author considers the 4 x 10 inch steroscopic film more diagnostic than the flat 14 x 17 inch film. These films were exposed primarily to determine the presence or absence of demonstrable pulmonary tuberculosis, but other abnormalities were plainly evident and reported to the individual's private physician. Seven hundred and thirty-three, or 3.7 per cent, revealed other abnormal conditions (Table II).

In this survey the percentage of primary tuberculosis (22.5 per cent) is low, while 70.8 per cent for the negative group is too high for two reasons: First, if the entire group had been tuberculin tested, the negative group would be reduced to approximately 47.6 per cent, according to our previous tuberculin test and x-ray survey.[1] In that

TABLE II

RECOMMENDATIONS ON ALL ABNORMAL CONDITIONS

| | | |
|---|---|---|
| Number of Films Giving Diagnostic Information | 6,571 | 33 per cent of 20,000 |
| Recommended: | | |
| 14 x 17 Films | 119 | 392 6 per cent of 6,571 Abnormal Films |
| Gastric Analyses | 157 | |
| Investigate Heart and Aorta | 82 | |
| Differential Diagnosis | 12 | |
| Hospitalization | 22 | |

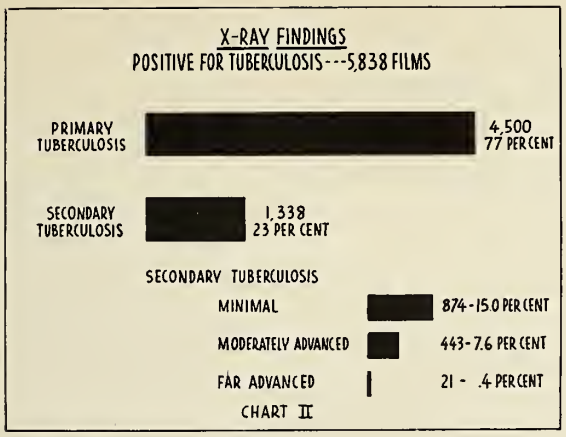



[1] Crimm, Paul D.; Potts, W. L., and Hudson, Gwen S.: Tuberculin Tests and Roentgenograms, A Correlation on One Thousand Adults, *Am. Rev. of Tuberc.*, Vol. XLII, No. 2, (August) 1940.

TABLE I

ACTIVE PULMONARY TUBERCULOSIS

| Of Total 20,000 | |
|---|---|
| Number of Positive Cases | 5,838—29.2 per cent |
| Number of Cases of Inactive Pulmonary Tuberculosis | 5,816—29.1 per cent |
| Number of Cases of Active Pulmonary Tuberculosis | 22— .1 per cent, or 1.1 cases per 1,000 |
| Number of Cases of Active Pulmonary Tuberculosis Reported to Hospital from Industry, who were not x-rayed by Mobile X-ray Unit | 18 |
| Total Number of Active Cases Discovered in Industry during one One Year's Survey | 40— 2.0 cases per 1,000 |




series of 1,000 Evansville industrial employees, each of whom had a tuberculin test and x-ray (14 x 17 inch), the percentage of cases having masked, or non-pulmonary lesions, was found to be 23.2 per cent.[2] Secondly, the present program was a voluntary one, and many who had a known family history of tuberculosis refused an x-ray.

### COMPARATIVE COSTS

To find open cases of tuberculosis and to further diminish the mortality rate, periodic x-ray examinations are indicated. It is an onerous program of x-ray inspection, because the maintenance of healthy lungs is not "in status quo." The old adage that "an ounce of prevention is worth a pound of cure" certainly holds true in preventing workers from becoming infected with tubercle bacilli. On the surface it looks like an expensive prevention, but with small x-ray films in use the cost is commensurate with industrial health budgets. In any analysis the cost of x-raying thousands of employees is much less than the amount of money appropriated through taxation for the hospitalization of a few active cases of tuberculosis. The cost of x-raying these 20,000 individuals was approximately $30,000. Valuable information was obtained for each employee at a cost of $1.50 each. Through the Mobile Unit twenty-two cases of active tuberculosis were discovered working in industry. If the medical information obtained for the 20,000 was of no value to any of them except the twenty-two individuals who had active tuberculosis, the cost for discovering each one equals $1,363 per active case. If your hospital stay could be shortened by one year, or your life saved for $1,363, you would gladly pay this for an early diagnosis. A lethal exodus from active pulmonary tuberculosis is inevitable if the diagnosis is dawdled, or if one ignores the accepted standards of treatment. The National Tuberculosis Association estimates that the average cost of illness (wage loss included) for six months is $2,750 per patient, six months to one year $3,125, and one year and over $3,950 (Table III).

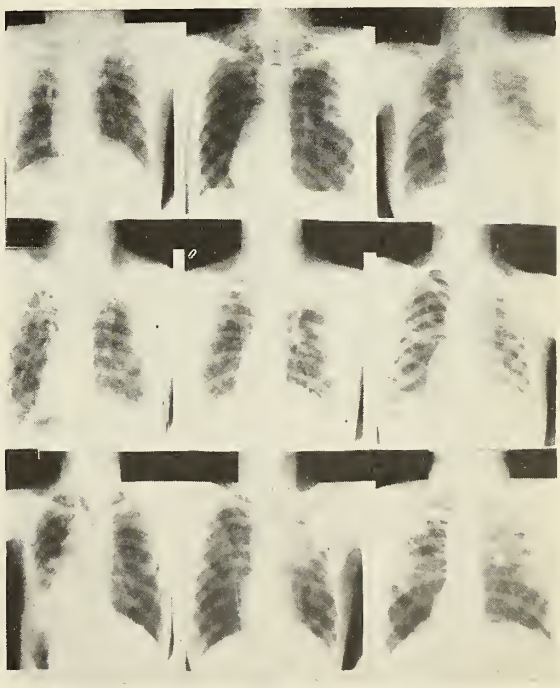
[2] Crimm, Paul D., and Short, Darwin M.: Tuberculin Anergy in Cases with Pulmonary Calcifications, *Am. Rev. of Tuberc.*, Vol. XXXIX, No. 1, (January) 1939.

### COMPULSORY X-RAY EXAMINATIONS

During this survey of one year's duration, not only were 22 active cases found by the Mobile Unit, but 18 active cases were referred to the hospital by physicians. These 18 active cases were working in industry, but were not x-rayed either because that particular industry did not offer the Mobile Unit to its employees, or because the employee refused to have an x-ray when it was available. Thus, a total of 40 active cases who were working among well employees were hospitalized. If the estimation is correct that one active case infects three new individuals, 120 new contacts might develop from the 40 active cases (Table III). If industry had demanded compulsory pre-employment x-rays of all employees, like the armed forces of the United States does, these 40 active cases, all of them moderately and far advanced, would not have been employed, but placed in quarantine without hazard to their co-workers.

The first prerequisite toward eradicating tuberculosis from an industrial plant is to x-ray the individual before he starts to work. Secondly, the voluntary method of x-raying plant employees produces tangible results, but morbidity and mortality rates can be further reduced only if every employee already at work is forced to have an x-ray. In turn, this employee must be protected by a compulsory pre-employment x-ray of every new employee. As a suggestion, it might seem fitting and proper that the cost of an x-ray for the prospective employee who is not hired because of tuberculosis be paid for

FIGURE II



*Radiographs showing far-advanced pulmonary tuberculosis with cavitation, fibrosis, and calcification. All have sputum positive for tubercle bacilli.*

**TABLE III**

**AVERAGE COST OF ILLNESS**

**(According to Length of Time Required to Treat Pulmonary Tuberculosis)**

**Average cost per patient, including wage loss, as determined by the National Tuberculosis Association:**

| | |
|---|---|
| Under 6 months | $2,750 |
| 6 Months to 1 year | 3,125 |
| 1 Year and over | 3,950 |

| | *Cases Requiring Treatment for One Year and Over* | *Estimated Cost of Illness* | *Approximate Cost of Discovery* |
|---|---|---|---|
| 22 | Active cases discovered by Mobile Unit | $86,900 | $30,000 |
| 18 | Active cases working in industry who were referred to hospital during survey | 71,100 | |
| 40 | Active cases—total cost | $158,000 | |
| 120 | Cases* (estimated number of people who might become infected by the 40 active cases, and who might break down and require 1 year or more of treatment) | $474,000 | |

If the 40 individuals had been discovered by pre-employment x-ray, the duration of illness and cost would be greatly reduced. Furthermore, had compulsory pre-employment x-rays been in vogue during the twelve months survey, 40 active cases would have been prevented from infecting other employees.

* It is estimated that for every active case of tuberculosis three other individuals become active cases.

by the employer. On the other hand, if the prospective employee is hired as a result of a normal chest, he not only knows that he has a job, but also that he has an x-ray which demonstrates the absence of a communicable disease. Therefore, the employee might be willing to pay for his initial x-ray.

### SUMMARY

1. Of 20,000 industrial employees who worked in Evansville during twelve months (1944-1945), 22 active cases of tuberculosis were discovered. Of the 20,000 employees, 14,162, or 70.8 per cent, were negative for pulmonary tuberculosis, while 4,500, or 22.5 per cent, had primary tuberculosis, and 1,338, or 6.7 per cent, had secondary pulmonary tuberculosis.

2. An additional 18 cases working in industry, who were not x-rayed by the Mobile Unit, made a total of 40 active cases, or 2 cases per 1,000.

3. Stereoscopic 4 x 10 inch films are almost paragon, for only 147, or 0.7 per cent of the 20,000, required 14 x 17 inch films for further diagnoses. Seven hundred and thirty-three, or 3.7 per cent, revealed other thoracic cage, heart and lung conditions.

4. Compulsory x-ray examination of all industrial employees, coupled with compulsory pre-employment x-rays, is necessary if morbidity and mortality rates of tuberculosis are to be reduced to the "law of diminishing return."

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## ABSTRACT

### PENICILLIN INHALED AS A MIST CURES RESPIRATORY INFECTIONS

A highly concentrated solution of penicillin, inhaled as a mist, has brought complete relief to persons suffering from bacterial infections of the respiratory tract.

Herbert N. Vermilye, M.D., of Forest Hills, N. Y., in the September 22 issue of "The Journal of the American Medical Association," reports the successful treatment of more than two hundred patients with the inhaled drug known as "aerosol penicillin."

The conditions treated successfully include pneumonitis, tonsillitis, sinusitis, sinobronchitis, pharyngitis, and bacterial asthma. These conditions all have a common denominator—the bacterial invasion of the respiratory tissues.

Aerosol penicillin has many advantages over the method of administration by injection into a muscle or vein, especially when bacterial invasions of the breathing apparatus are under treatment. With the injection method, frequent muscular or venous injections are necessary. This usually means that hospitalization and continual medical supervision with nursing care are essential. However, none of this is necessary with aerosol penicillin, since it may be easily administered in the home or in the doctor's office through a mouthpiece or oxygen mask.

Another advantage is that inhalation of penicillin mist introduces the drug directly into the site of bacterial invasion and produces a high local concentration at the point of the infection. Dr. Vermilye emphasizes the fact that aerosol penicillin was repeatedly found to control infections of the upper respiratory tract which were not cured by penicillin injections or which relapsed after its use.

The author stated that in an epidemic of an unclassified virus disease of the upper respiratory tract during the late winter months of the past year, aerosol penicillin was used to good effect. "While the virus infection itself was probably not influenced by the drug," the doctor pointed out, "the patients frequently were definitely benefited because secondary bacterial infections did not arise to complicate the original disease. Many patients appeared to be well after treatment for one or two days although penicillin was continued for about five days. Perhaps one factor in the rapid recoveries was the general feeling of well being and the increased appetite which commonly accompany aerosol penicillin treatment. Similarly, the duration of colds has been repeatedly shortened because of the elimination of secondary bacterial invasions."

Dr. Vermilye adds that "the administration of penicillin by inhalation is suggested as a valuable substitute for the usual technic. It is an adaptable method, useful in the home by untrained persons and in the office. It can be utilized for continuous or intermittent administration of penicillin in severe as well as in less dangerous chronic infections, in which from three to five treatments during the day apparently are sufficient to effect removal of the infection."

# NEGATIVE CHEST FINDINGS IN A MINERAL WOOL INDUSTRY

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ALEXANDRIA

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## INTRODUCTION

Mineral wool[1] is a substance composed of very fine, interlaced mineral fiber, having the appearance of loose wool or cotton. It is a fibrous glass-like material composed chiefly of silicates of calcium and aluminum, together with minor constituents. Thus, mineral wool is a generic term covering a number of similar products differentiated chiefly by the raw materials from which they are made. These "similar products" are:

1. Rock wool—made from natural rock or from a combination of various natural minerals.
2. Slag wool—made from iron, copper, or lead blast-furnace slag.
3. Glass wool—made from sand, soda ash, limestone, with or without scrap glass.

The chest findings noted in this discussion will refer to exposures to rock and slag wool only.

Glass wool, according to the studies done by Siebert[2] does not produce any pulmonary changes demonstrable by x-ray.

The first large development of rock wool in this country was at Alexandria, Indiana, by C. C. Hall, in 1897.[3] Hall found that the agrillaceous limestone found in this area could be processed into a high grade mineral wool without fluxing. This limestone deposit became so widely known that a chemical dictionary[4] has defined rock wool as "a product consisting of a fibrous mass, made from agrillaceous limestone quarried in the neighborhood of Alexandria, Indiana." Thus, for some time Indiana has been the home of the rock wool industry.

## CHEMICAL COMPOSITION OF ROCK AND SLAG WOOL

The following analysis of cupola materials was submitted by the chemists of the plant under study:

| | | *Rock* | *Lead Blast Furnace Slag* | *Blast Furnace Slag* | *Blast Furnace Slag* |
|---|---|---|---|---|---|
| Silica | $SiO_2$ | 32.5 | 29.5 | 51.5 | 35.0 |
| Alumina | $Al_2O_3$ | 8.5 | 16.5 | 16.0 | 12.0 |
| Ferric Oxide | $Fe_2O_3$ | 2.0 | 30.0 | 6.5 | 1.0 |
| Calcium Oxide | $CaO$ | 17.0 | 11.0 | 21.5 | 43.0 |
| Magnesia | $MgO$ | 12.0 | 4.0 | 4.5 | 8.5 |

The silica reported is the total combined silica. Free silica determinations on the finished rock wool by chemical methods of analysis show the product to contain from a trace to one-half per cent free silica. All iron reported in above table is in terms of $Fe_2O_3$.

## DUST STUDIES

The original dust study was done in 1934 by the Metropolitan Life Insurance Company, at the direction of Dr. W. J. McConnell. Atmospheric samples were collected in a Smith-Greenburg impinger and light field counts were made. Dust counts ranged from twelve million per cubic foot of air to thirty-six million.

Following this, various control measures reduced the dust concentrations to a level of five to ten million particles per cubic foot of air. Cumulative totals for the number of years workers have been exposed showed that of the eighty-three workers in the exposed group, sixty-three, or 76 per cent, of the group under study had an exposure greater than ten to fourteen years. Thus, the bulk of the workers under study were exposed during the major portion of their industrial life, to the dust concentrations reported by McConnell rather than to the lower ones achieved through effected control procedures. This group, in our opinion, would thus serve as a satisfactory study group from the standpoint of length and concentration of exposure.

## CHEST FINDINGS

The first detailed chest studies in this plant were done by the Industrial Health Section of the Metropolitan Life Insurance Company, by Lanza and McConnell in 1934. At that time 183 x-rays were read. The range of exposure was up to eighteen years with prevailing dust counts as reported. All these films were classified as "negative for pneumonoconiosis." Since that time some twenty-three hundred films have been taken as part of the routine follow-up medical program. Of this number we selected for further study only those workers who had an exposure of more than seven years' duration. Thus, we had for study eighty-four workers whose exposure varied from seven to twenty-six years. All of the men were employed in one plant having the exposure discussed in previous paragraphs. This plant has within the past ten years used the slag wool formula exclusively.

* Medical Director of the Mineral Wool Plant under study.

† Director, Division Industrial Hygiene, Indiana State Board of Health.

[1] *Mineral Wool*, U. S. Dept. Interior, I. C. 6984, (Jan.) 1938.

[2] Siebert, W. J.: Fiberglass Health Hazard Investigation, *Ind. Med.*, **11**:6-9, (Jan.) 1942.

[3] Stewart, Joseph, and Richardson, C. D.: One-Hundred Years of Mineral Wool, *News Edition*, American Chem. Soc., **18**:997-998, 1940.

[4] Turner, F. M., et al.: *Condensed Chem. Dict.*, Chem. Cat. Co., N. Y., p. 313.

Thus, the majority of men were exposed to both rock wool and slag wool. X-ray examination of the chest, by use of standard films, showed the following findings:

a. Forty-three employees had definite exaggerated linear markings.

b. One employee had healed reinfection type of tuberculosis.

c. One employee exhibited dextrocardia.

d. One employee had second degree silicosis.

The case of the second degree silicosis has a history of working in a refractory brick batch house for one and one-half years, exposed to ganister dust. Nodules were present on the preemployment x-ray examination.

The only apparent constant findings were the exaggerated linear markings. Fifty-one per cent of the sample showed this finding. The age group of the exposed sample (Table I) varied from thirty to seventy-four years, with the preponderance of employees in the age group thirty to fifty-four. Whether these linear markings were due to exposure to rock wool or were normal for that age group in that community could not be answered unless we could compare x-ray films of the same age group living in the same community, and having no exposure to rock wool.

TABLE I

**Age distribution of the workers exposed to mineral wool dust**

| *Age* | *Number of Workers* |
|---|---|
| 30-34 | 13 |
| 35-39 | 15 |
| 40-44 | 12 |
| 45-49 | 17 |
| 50-54 | 15 |
| 55-59 | 6 |
| 60-64 | 3 |
| 65-69 | 2 |
| 70-74 | 1 |

This was done by using the office force's preemployment films, and others about the plant not working in mineral wool. The age distribution of the control group, according to Table II, varied from twenty-five to fifty-nine years. This is essentially the same distribution as Table I. In this group of ninety workers we found forty-eight, or 53 per cent, that had definitely exaggerated linear markings. Therefore, this finding cannot be attributed to rock wool, but is a consistent finding of the age group living in that community. Other x-ray findings in the control group were as follows:

a. Three employees had enlarged hearts.

b. One employee had a tented diaphragm.

c. One employee had a curvature of the spine.

d. Two employees had calcified areas in the periphery of the left chest—activity questionable.

e. One employee had small, soft, irregularly-shaped nodules bilaterally.

TABLE II

**Age distribution of workers not exposed to mineral wool dust**

| *Age* | *Number of Workers* |
|---|---|
| 20-24 | 6 |
| 25-29 | 18 |
| 30-34 | 19 |
| 35-39 | 11 |
| 40-44 | 8 |
| 45-49 | 20 |
| 50-54 | 4 |
| 55-59 | 4 |

The employee demonstrating nodulation was a welder, and his chief job was to repair boilers. His welding was done in confined spaces, and he probably has siderosis of welders, as described by Sander.[5]

Sayers, in a Department of Interior publication,[1] (page 15) states, "From some experiments we have performed, using mineral wool fibers, we have found that particles remain in the tissue, producing an inert foreign body reaction similar to that of asbestos, and we have been considering dust from mineral wool as potentially harmful, that is, capable of producing a diffuse pulmonary fibrosis, when inhaled." The findings reported by Lanza and McConnell in 1934, or our present findings, did not substantiate this belief. An analysis of Table III shows that the duration of exposure in years would have been long enough to produce any fibrosis or silicosis if this product were capable of producing such changes.

TABLE III

**Number of years workers were exposed to mineral wool dust**

| *Years Exposure* | *Number of Workers* |
|---|---|
| 7- 9 | 21 |
| 10-14 | 35 |
| 15-19 | 22 |
| 20-24 | 4 |
| 25-29 | 2 |

## SUMMARY

1. Eighty-four workers exposed to mineral wool for periods ranging from seven to twenty-nine years showed no x-ray evidence of silicosis or fibrosis of the lungs. This includes ten years of exposure to slag wool.

2. The exaggerated linear findings exhibited were shown to be a characteristic of that community for the age group under study.

3. The duration of exposure for the sample group under study was long enough to produce any pulmonary changes if rock wool were capable of producing a fibrosis.

4. The free silica content of finished rock wool was found to be a trace to one-half of one per cent.

[5] Sander, O. A.: Further Observations on Lung Changes in Electric Arc Welders, *Ind. Med.*, **13**:70, 1944.

# ESTIMATION OF DISABILITY IN SILICOSIS

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The accurate estimation of disability in silicosis is one of the complex problems of industrial medicine. There are no short cuts by which this disability can be determined, and many factors must be considered. The symptoms of silicosis, namely, dyspnea, cough, tightness in the chest, and fatigue can be found present in other pathological conditions and are not pathognomonic of silicosis. It is therefore imperative that a diagnosis of silicosis be made before proceeding with studies that may aid in the estimating of disability.

Several pertinent questions arise in the study of a suspected silicotic with possible disability:

1. *How much silica has this man retained in his lungs?*

A history of adequate exposure to silica should be obtained. Engineering reports of the aerial dusts of the working area are helpful. Dust sampling and further studies, such as particle counts, the percentage of free silica, the percentage of particles below 5 microns, and a chemical analysis to determine the presence or absence of inhibitors or accelerators should be made. It is a well-known fact that certain dusts when mixed with silica alter the action of this latter substance. Laboratory tests, such as sputum, blood, and urine studies, may be helpful. Incinerating the sputum and finding abnormally high quantities of silica is evidence of exposure only, and not an index to the amount of disease or disability. Increased concentrations of the silicate ion in the blood and urine indicate increased silicious absorption, but not necessarily from silica in the lung. Personal knowledge of the exposure, plus x-ray and autopsy reports, aid in evaluating this exposure.

2. *What evidence of silicosis can be demonstrated by physical methods?*

X-ray studies showing the characteristic anatomic changes due to silicosis must be present. It must be remembered that the x-ray picture in silicosis varies from industry to industry, plant to plant in the same industry; job to job in the same plant, and even individual to individual on the same job. These variations can be accounted for by differences in the dust counts, the percentage of silica present, the particle size, and the admixtures of dust and pecularities of the individual. It is impossible to estimate the degree of disability in silicosis from the x-ray film alone. The differential diagnosis should include the welders lung,[1] fungus infection, tuberculosis, metastatic malignancy, and barytosis, et cetera. The physical examination is important, and negative findings are expected in simple silicosis when the subject is examined by routine methods. Pulmonary conditions other than silicosis can be evaluated during further study.

3. *What evidence of lung dysfunction due to silicosis can be demonstrated?*

When the diagnosis of silicosis is established, one can then proceed to estimate the disability that may be present. It must be emphasized that this study be thorough, and in certain cases should not be limited to one type or one examination. Too frequently the physician is called upon to diagnose silicosis and estimate the disability in a suspected silicotic in a very short period of time, which in some cases may be measured in minutes, *but* there is no substitute for time and experience.

The physical examination should be thorough, and every effort should be made to evaluate pathological conditions that are present in addition to silicosis. The subject should be examined in the morning, after a good night's sleep, and under basal conditions, or at least after a very light breakfast. The chest examination should include the basic elements of physical examination:

*Inspection:*

This study should include observations made while the patient is walking about the examining room, during the process of removing his clothing prior to the examination, and the local inspection of the chest. Any degree of dyspnea should be noted and recorded for further evaluation. Inspection of the chest should include particular attention to the use of the accessory muscles of respiration as well as observations relative to the excursion of the chest wall. Dyspnea developing during conversation should also be noted.

*Palpation:*

Palpation reveals nothing of significance except in conglomerate silicosis where an increase in tactile fremitus can be expected. Anteroposterior chest measurements should be made, and any deviation from normal should be noted. An increase in the diameter is significant of disease within the chest cavity.

*Percussion:*

Again there is little or no variation from the normal except in the presence of conglomerate silicosis or severe complicating emphysema.

*Auscultation:*

In far-advanced silicosis with extreme disability the breath sounds may be harsh and bronchial or tubular in quality. Having the subject breathe

[1] Enzer, N., and Sander, O. A.: Chronic Lung Changes in Electric Arc Welders, *J. Ind. Hyg. and Tox.*, **20**:333-350, (May) 1938.

forcibly, such as panting, will modify the breath sounds in a silicotic and cause them to change to a tubular quality. Continued forced ventilation may lead to bronchospasm and an increase in residual air in the lungs. This condition is the cause of the symptom "tightness in the chest." The author believes that such bronchospasm is an important cause of disability in silicosis. The temperature, pulse, and respiratory rate should be recorded and evaluated, and every effort should be made to evaluate disabling physical conditions that may exist in addition to silicosis.

At the present time there is a divergence of opinion not only to respiratory function tests, but also to the interpretation of these tests. For this reason the author makes no attempt in this article to present definite set standards as to methods of examination, the type of tests, or arbitrarily set standards for these tests.

*Respiratory function tests:*

Respiratory function tests are of value as an aid in estimating the disability in silicosis, but the results of these studies should always be correlated with other findings. The numerical result of the tests should not be the outstanding fact, but observations on the amount of coughing, dyspnea, tightness in the chest, and changes in breath sounds should be included, as well as the recovery time. A very low reading obtained in a forced breathing test should not be accepted unless accompanied by symptoms of respiratory distress.

Lung function tests are based on normal standards that can be compiled locally, using the same apparatus and technique each time. The examiner should complete studies of normal individuals in his locality, and these studies may be made a part of the pre-employment examination until sufficient data is gathered. It is essential that standard equipment be used for each test and that its use be continued after normal values are established. It is possible to use six different breathing valves in estimating maximum minute ventilation and obtain six different results in the same individual. There may be a marked difference in the highest and lowest values. Records of normal values are few and difficult to evaluate because the studies were made under varying conditions and different techniques.

Lung function tests that have been found helpful in estimating disability in silicotics are as follows:

1. *Measuring the components of total pulmonary capacity:*[2]
   a. *Tidal air*—Volume of air taken into the lungs during rest.
   b. *Complemental air*—Amount of air taken into the lungs from the position of resting respiration level—includes tidal air.
   c. *Reserve air*—Volume of air that can be forced from the lungs following a normal expiration.
   d. *Vital capacity*—The amount of air expired in the fullest possible expiration, and includes the tidal, complemental, and reserve volumes.
   e. *Residual air*—The air remaining in the lungs after the fullest possible expiration.

The tidal air, complemental air, and reserve air can be measured by a basal metabolism spirometer; the vital capacity by use of a simple spirometer or vitalometer. The residual air can be measured by the 'Oxygen Dilution Method of Christie',[3] but this test is lengthy and requires elaborate apparatus as well as exacting technique. Estimating the residual air is of prognostic value.

2. *Normal minute ventilation and normal tidal volume* is measured by having the subject seated at rest and collecting all of his expired air for a period of seven minutes. The air is measured and divided by the number of respirations, giving the *normal tidal volume.*

3. *Maximum minute ventilation and maximum tidal volume* is measured by having the subject stand and breathe as forcibly as he can into a Douglas or similar bag at a rate of sixty times per minute. The air is measured and the volume is interpreted as *maximum minute ventilation.* The air breathed, measured in cc.'s, is divided by the number of respirations, and this figure is the *maximum tidal volume.*

4. *Pulmonary Reserve* is the difference between the normal tidal volume and the maximum tidal volume. This amount of air represents the reserve respiratory function available to the individual when carrying on activities that place a demand on the lungs for more oxygen.

5. *Exercise tests* can be employed. McCann and Kaltreider[4] pioneered in this field and advocated the bicycle ergometer, later Wright[5] employed the treadmill ergometer.. The dynamic work test described by Enzer,[6] and stepping or climbing tests have also been recommended. In exercise tests the individual performs a standardized and measurable amount of work while his expired air is measured each minute. The result is expressed as *exercise minute volume.* All of these studies are directed toward establishing the relation between normal minute ventilation, exercise minute ventilation, and maximum minute ventilation. The closer the exercise minute ventilation approaches the maximum minute ventilation, the greater the dyspnea. It is considered that when a person uses more than a certain per cent of his maximum ventilation, dysp-

[2] Hurtado, A.; Kaltreider, N. L.; Troy, W. W.; Brooks, W. D. W., and McCann, W. S.: Studies of Pulmonary Capacity, *J. Clin. Invest.*, **XIII**, No. 6, (Nov.) 1934.

[3] Christie, R. V.: The Lung and its Subdivisions—Methods of Measurements, *J. Clin. Invest.*, **13**:169, 1933.

[4] Kaltreider, N. L., and McCann, W. S.: Respiratory Response During Exercise in Pulmonary Fibrosis and Emphysema., *J. Clin. Invest.*, Vol. XVI, 23-40, No. 1, (Jan.) 1937.

[5] Wright, G.: Publications of the Industrial Hygiene Foundation of America, 1943.

[6] Enzer, N.; Simonson, E., and Evans, E.: Clinical Physiological Observations on Welders with Pulmonary Siderosis and Foundry Men with Nodular Uncomplicated Silicosis, *J. Ind. Hyg. and Tox.*, **27**:147-158, No. 6, (June) 1945.

nea appears, due to a decrease in the pulmonary reserve.

The above tests have been found of great aid in estimating disability, but again it must be stressed that respiratory function tests alone cannot give the whole answer in the estimation of disability.

Various methods and tests have been used by different investigators, but as yet these workers are not in agreement as to the simplest and most efficient test that can be used by the industrial physician. The current work of Wright, McCann and Kaltreider, Drinker and Enzer, Simonson and Evans should be followed closely. It is hoped that some simple test may be developed by these investigators that will provide the answers in lung-function studies. However, the findings will have to be correlated with the history, x-ray studies, and physical findings.

*Conclusion:*

1. A diagnosis of silicosis must be made before the estimation of the degree of pulmonary disability is attempted.
2. Pathological conditions other than silicosis that may contribute to disability should be evaluated.
3. Disability can be estimated by correlating the physical findings with the results of lung-function tests.
4. At the present time there is no substitute for time and experience in estimating pulmonary disability in silicosis.

## ABSTRACTS

### SIMILARITIES BETWEEN TWO TYPES OF JAUNDICE

Four investigators have just completed an exhaustive study to ascertain what similarities exist between jaundice caused by injection of whole blood, blood plasma, or serum, and the jaundice which is infectious. They found the disease agent or "virus" of the two types of jaundice to be similar in most respects.

John R. Paul, M.D., New Haven, Connecticut, Major W. P. Havens, Jr., and Lieutenant Colonel A. B. Sabin, both of the Medical Corps, Army of the United States, and Lieutenant Colonel C. B. Philip, Sanitary Corps, Army of the United States, report on their human transmission experiments, which they carried out in the Middle East and later supplemented in this country, in the July 28 issue of "The Journal of the American Medical Association."

Jaundice occurs when a bile pigment or coloring matter called bilirubin gets into the blood and causes a yellowish discoloration of the skin, the mucous membranes and the fluids of the body.

The serum jaundice is produced by an injection of whole blood, serum, or plasma which ordinarily has been obtained from an individual who has had no history of jaundice. Numerous examples have resulted from the preventive injection of serum for measles, mumps, and other virus diseases.

The infectious jaundice or infectious hepatitis—inflammation of the liver—is usually an epidemic disease. The manner in which it spreads from person to person is not completely known, but the disease does flourish under poor sanitary conditions and frequently follows outbreaks of intestinal disease. One scientist, studying the disease among New Zealand soldiers at Alamein in Egypt, believed that the disease was spread by flies.

"Exact knowledge as to immunity in this disease," the authors state, "is not yet available. It has been noted that troops newly introduced into an endemic or epidemic area are more susceptible to infectious jaundice than is the local population."

In their transmission experiments with human volunteers, the investigators state that the results indicate the disease agent or agents of serum jaundice and of infectious jaundice are quite similar, as is also the clinical picture of the disease produced. The viruses of the two types are both filtrable, which means that the micro-organisms are so small that they are able to pass through the pores of porcelain or earth filters. Both are also relatively resistant to heat.

The prominent difference between serum jaundice and infectious jaundice lies in the length of the incubation period, which is the duration between the time the virus is introduced into the body and the appearance of visible symptoms. The incubation period for the infectious type was from eighteen to thirty days in contrast to the sixty to one hundred twenty days in the case of the experimental serum jaundice.

Discussing the problem of immunity, the authors say: "Three patients who had recovered from serum jaundice six months before were not found to be immune to experimentally-induced attacks of infectious hepatitis. However, little is known regarding immunity in infectious hepatitis, and the case with which these three patients were 'reinfected' is not regarded as an indication that the two diseases are fundamentally different."

### OFFICERS TELL HOW THEY CONTROLLED DYSENTERY AT INDIA AIR BASE

How Army medical officers controlled outbreaks of dysentery at an air base near Calcutta, India, is told in an article appearing in the September 15 issue of "The Journal of The American Medical Association."

Two flight surgeons, Captain Edgar A. Lawrence and Captain Robert E. Bennett, report that during July, 1944, there were two hundred and five cases, or approximately double the incidence of any previous month. The doctors said they did not believe the increase could be considered as an epidemic, but rather a result of the rainy season and the natural increase in fly breeding.

The doctors said that poor sanitation near the air base was conducive to spread of the disease, and that every case had to be looked on with grave suspicion and examined individually. Decaying garbage, human and animal excreta, and occasional foul-smelling carcasses of dogs and cattle left lying for days at a time were the usual conditions found in the densely-populated, disease-ridden Indian villages.

"Obviously," the authors said, "conditions of that kind are extremely conducive to the breeding of flies in and around the base."

In an effort to determine the degree of fly hazard, as far as transmission of dysentery is concerned, an interesting experiment was carried out. Live flies were picked up from screens by forceps and allowed to crawl over a plate. Eighty-eight per cent of the flies were shown to be carrying the organisms which cause dysentery—particularly the one-celled organism which causes amebic dysentery.

The particular ameba which causes this disease lives in the human intestinal tract. In acute cases of dysentery actively-moving ameba may be found, while in the chronic cases, even without diarrhea, the ameba may be found in the form of cysts. It is in the form of cysts that the disease is usually carried and individuals who pass these cysts in their stools are called "carriers."

Thorough diagnosis and early treatment is stressed, since many untreated early cases of amebic or bacillary dysentery tend to become chronic quickly, often leading to lifelong invalidism. The Army doctors point with pride to the fact that there were no deaths or complications resulting from the dysentery outbreak at the air base.

The officers state that "stringent sanitary measures in the surrounding area of the base were carried out." Latrines, buildings, tent areas and all open air breeding places were sprayed with the new insecticide, DDT. Screens and garbage cans were checked. "The control of flies by these measures," the doctors said, "was both dramatic and gratifying."

Where possible, in the command, all carriers of amebic or bacillary dysentery were separated and treated. Due to the difficulties of individual treatment among the Indian food handlers, mass treatment was begun as a means of weeding out, as far as possible, the amebic carriers.

"As a result of these control measures and prompt isolation of dysentery cases there has already been a definite and appreciable drop in the incidence of diarrhea and dysentery," the authors said.

# THE STORY OF FRENCH LICK

*Entrance to French Lick Springs Hotel*

Nearly two hundred years ago a French trading post was established at French Lick, which for five hundred years prior had been the hunting grounds of the Indian. These early settlers discovered that animals, deer, bear, and even the wily fox, came to the springs to lick the water and wet rocks, the minerals in the waters acting as a natural tonic. Pathways from every direction led to the springs, and one of the early white pioneers aptly named it "The Lick." Joel Charles led in the movement to establish the first permanent white colony here in 1811; a fort was built for protection against the Indians, and the name "French Lick" came into being. A civil form of government was created in 1817, when there were twenty-four men of voting age in the colony, and Joel Charles was elected the first justice.

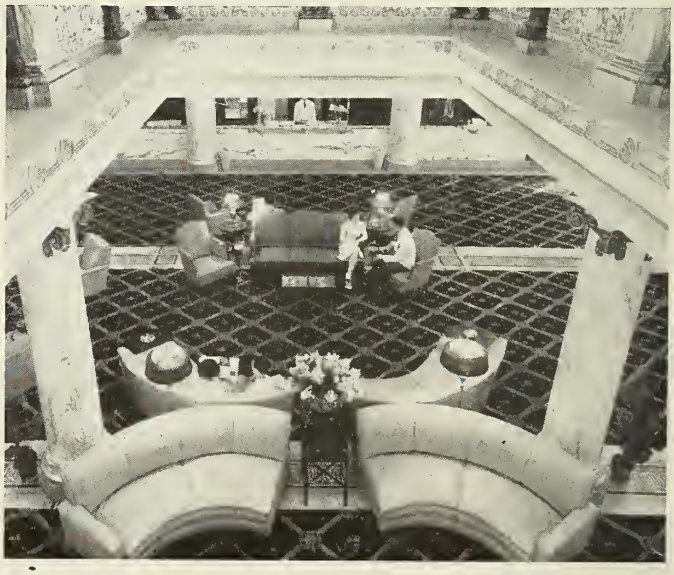
The white men heard rumors among the Indians that silver and lead in unlimited quantities were to be found in the caves and mines about French Lick, but due to the constant friction between the races, the red men carefully concealed the secret of this ore, and when they fled farther westward the key to its discovery went with them.

Excitement reigned high in French Lick in 1850, when two strangers appeared from Canada with the story that they had secured from an old Indian squaw, who had lived near French Lick, directions for finding silver and lead in a cave three miles from French Lick. The entire colony joined in the search, but to no avail. But even to this day reports of the existence of the metals crop up, and inhabitants renew the search.

The secret of another treasure at French Lick, however, was solved in easier fashion. Dr. William A. Bowles, statesman, soldier, and a leading figure in the community, foresaw the future of the mineral waters, purchased the great tract of land about the springs in 1832, and in 1840 erected the first hotel at French Lick Springs.

It was an ungainly frame building, but to the hardy pioneers of that day it was a veritable paradise. It was not an uncommon sight to see covered wagons, buckboards, or even travelers on horseback arriving for the famed cure. When they departed they were laden down with jugs and containers filled with the rejuvenating waters. Later, Doctor Bowles conceived the idea of boiling down the water that his patrons might carry away larger quantities.

To Doctor Bowles' foresight goes much of the credit for the development of French Lick Springs. He retained possession of the property for a total of forty-one years, and when he passed to his reward in 1873 his name was world-famous. In 1891 the vast estate was taken over by the present corporation which Senator Taggart headed. And it was under the Senator's direction that the present-day structure was built to replace the old hotel buildings. The hotel is a city within itself, operating its own water plant, electric light plant, and a laundry adequate for serving a town of twenty thousand persons. A stable of fifty three- and five-gaited horses; a model dairy farm, consisting of more than one hundred fifty graded cows; two championship golf courses; tennis and badminton courts; a Skeet Club, and the airport are other features. The famous baths are administered in specially-constructed wings of the hotel, and in conjunction with them is operated a modern gymnasium and two swimming pools.



*Main Lobby, French Lick Springs Hotel*

# An Invitation

to

## Members of The Indiana State Medical Association

## To Celebrate "M-D Day"

The long-awaited "V-E" and "V-J" days came, and were acclaimed in sincere thanksgiving and joyous celebration. Now the next in order is "M-D Day," the day that you have earned and deserve—a day of celebration for all doctors weary from many months of service and overwork on the home front.

The date has been set by your state association—November 6, 7, and 8. The place—French Lick Springs Hotel, that heaven on earth for the tired and brain-fagged physician.

We are planning the party, so we invite you to come to French Lick and enjoy the treat that is in store for you. Here in the beautiful hills of southern Indiana the grass is green and the flowers bloom in November. The autumn foliage presents a gorgeous panorama. Here you can rest and relax in luxurious comfort, and leisurely feast on the finest of food—no home or office telephones to torture you, and no parrot shrieks over hospital call systems to jangle your nerves.

This is to be no curtailed wartime state meeting; this is the vitally important postwar convention of the Indiana State Medical Association, and a glorious celebration of "M-D Day."

Come early, greet your colleagues returning from the armed forces, and mingle with your buddies on the home front. You will be thrilled and enlightened by the excellency of the scientific program, presented by carefully-selected leaders of the American medical profession. You will see the newest and best in scientific and commercial exhibits. Your presence is definitely needed to help solve postwar problems that threaten your future course in the practice of medicine.

And now for the trimmings: well that's where we come in. We are mobilizing all the resources of the Orange County Medical Society, The Third District Medical Society, and all the facilities of the great French Lick Springs Hotel to put on a postwar program including the prewar attractions of trap shooting golf entertainment for the ladies, a smoker that will be a rejuvenation, and a banquet that will push the ancient Roman feasts and the Days of Pompey out of the history books.

That's why we are extending this special invitation to you to come to French Lick. You can not celebrate "M-D Day" by staying home and reading about it in THE JOURNAL.

It has been a long time since you took "mom" anywhere, and how she does love French Lick!

COMMITTEE ON CONVENTION ARRANGEMENTS
Augustus P. Hauss, M.D.,
Clarence E. Boyd, M.D., *Co-Chairmen*
WOMEN'S ENTERTAINMENT
Mrs. James Baxter, Jr., *Chairman*

ORANGE COUNTY MEDICAL SOCIETY
and
THIRD DISTRICT MEDICAL SOCIETY

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## Golf Tournament

Plans for an old-time, all-medic golf fest are in the bag for Tuesday, November 6, starting at 8:00 A.M. Eighteen holes with prizes for low net and low gross scores. See entry blank below.

GOLF COMMITTEE
Herbert P. Sloan, New Albany, *Chairman*,
H. B. Shacklett, New Albany,
J. T. Carney, Jeffersonville,
A. R. Oleck, New Albany.

(Please complete, clip out and mail)

**TO: Indiana State Medical Association,**
**1021 Hume Mansur Building,**
**Indianapolis 4, Indiana.**

I will .....or will not.....play in the Golf Tournament.....

County ..... Handicap..... Home Golf Club.....

Name .....

Address .....

# Official Program

## Ninety-sixth Annual Session
## INDIANA STATE MEDICAL ASSOCIATION
## French Lick, Indiana
## November 6, 7, and 8, 1945

*(Schedule will be carried out on Central Standard Time)*

*Monday, November 5, 1945*

Annual Indiana Health Officers' Conference

6:30 p.m. Executive Committee dinner and meeting, Parlor B, main floor, French Lick Springs Hotel.

*Tuesday, November 6, 1945*

**Morning**

7:30 a.m. Council breakfast meeting, Blue Room, French Lick Springs Hotel.

8:00 a.m. Registration starts, north porch, off main lobby, French Lick Springs Hotel.

8:00 a.m. Opening of Commercial Exhibit, main lobby, north porch, and foyer to convention hall, French Lick Springs Hotel.

8:00 a.m. Opening of Scientific Exhibit.

8:00 a.m. Annual Golf Tournament. Eighteen holes. low gross and handicap medal play.

**Afternoon**

1:00 p.m. Meeting of House of Delegates, Main Convention Hall, French Lick Springs Hotel.

1:00 p.m. Trap Shoot, if enough members signify interest.

3:30 p.m. Special meeting of House of Delegates to consider report of Committee on Prepayment of Medical and Surgical Care, Main Convention Hall, French Lick Springs Hotel.

**Evening**

6:30 p.m. Annual dinner meeting for Women Physicians, Blue Room, French Lick Springs Hotel.

7:00 p.m. Smoker and stag party.
Award of golf and trap shoot prizes.

*Wednesday, November 7, 1945*

**Morning**

7:30 a.m. Breakfast meeting of members of the State and County Anti-Tuberculosis Committees, Bamboo Room, French Lick Springs Hotel.

7:30 a.m. Breakfast meeting of members of the State and County Committees on Industrial Health, Blue Room, French Lick Springs Hotel.

7:30 a.m. Breakfast meeting of Committee on Secretaries' Conference, Parlor B, main floor, French Lick Springs Hotel.

8:00 a.m. Registration continues, north porch, off main lobby, French Lick Springs Hotel.

8:00 a.m. Commercial Exhibit, main lobby, north porch, and foyer to convention hall, French Lick Springs Hotel.

8:00 a.m. Scientific Exhibit.

### GENERAL MEETING

**(Main Convention Hall, French Lick Springs Hotel)**

*Wednesday, November 7, 1945*

9:15 a.m. Call to order by N. K. Forster, M.D., Hammond, President, Indiana State Medical Association.

9:20 a.m. Greetings by A. P. Hauss, M.D., New Albany, and C. E. Boyd, M.D., West Baden Springs, co-chairmen of Committee on Convention Arrangements, and introduction of officers of Orange County and Third District Medical Societies.
Official Welcome by Thomas Taggart.

9:30 a.m. President's Address, N. K. Forster, M.D., Hammond.

### SCIENTIFIC PROGRAM

*Wednesday, November 7, 1945*

10:00 a.m. to 12 m. Panel discussion.

Subject: *The Disabled, the Physician, and Employment.*

Moderator—C. M. PETERSON, M.D., Secretary, Council on Industrial Health, American Medical Association, Chicago.

Participants—

J. R. CRAWLEY, Director Vocational Rehabilitation, Indianapolis.

E. H. HARE, M.D., Chief Medical Officer, Veterans Administration Facility, Indianapolis.

HARLEY KRIEGER, M.D., Medical Director, Ford Motor Company, Detroit.

HAROLD A. VONACHEN, M.D., Medical Director, Caterpillar Tractor Company, Peoria, Illinois.

E. S. JONES, M.D., Chairman, Committee on Industrial Health, Indiana State Medical Association, Hammond.

CREIGHTON BARKER, M.D., Executive Secretary, Connecticut State Medical Society, New Haven.

Subjects—

1. "Objectives of Rehabilitation."
2. "The Veterans' Program."
3. "Federal - State Rehabilitation Services."
4. "Placing the Handicapped in Industry."
5. "Community Organization for Rehabilitation."
6. "Part to be Played by Medical Society."

**Noon**

12:15 to 2:15 p.m. Fraternity, class, special committees, and servicemen's luncheons and get-togethers.

12:15 p.m. War Participation luncheon, Main Dining Room, French Lick Springs Hotel, Charles R. Bird, M.D., Chairman, Procurement and Assignment Service for Indiana, presiding. Everyone invited. Tables will be reserved for fraternities, classes, and special groups.

Speaker: GEORGE F. LULL, Major General, A.U.S., Deputy Surgeon General, Washington, D. C.

Subject: *Repercussions.*

Speaker: WATSON B. MILLER, Federal Security Administrator, Washington, D.C.

Subject: *The Medical Profession Today and Tomorrow.*

## GENERAL MEETING

**Afternoon**

**Main Convention Hall, French Lick Springs Hotel**

*Wednesday, November 7, 1945*

2:15 p.m. JOHN RALSTON LINDSAY, M.D., Professor of Surgery, University of Chicago, The School of Medicine, Chicago.
Subject: *Ménière's Syndrome.*

3:00 p.m. LIEUTENANT COLONEL TRUMAN G. BLOCKER, Jr., M.C., Chief, Plastic Surgery Section, Wakeman General Hospital, Camp Atterbury, Indiana.

Subject: *Problems of Maxillo-Facial Surgery, World War II.*

3:45 p.m. LORING TIFFANY SWAIM, M.D., Boston, Massachusetts.
Subject: *Arthritis.*

4:30 p.m. Section meetings. Following adjournment of the general meeting, meetings will be held of the five sections to transact general business matters and elect section officers for 1946, that is:

Surgical Section.

Medical Section.

Section on Ophthalmology and Otolaryngology.

Section on Anesthesia.

Section on General Practice.

**Evening**

7:00 p.m. Annual banquet, Main Dining Room, French Lick Springs Hotel.
Presiding officer, N. K. Forster, M. D., President, Indiana State Medical Association.
Presentation of Certificate of Merit to Jacob T. Oliphant, M.D., president 1944, Indiana State Medical Association, by N. K. Forster, M.D.

Speaker: Honorable Ralph F. Gates, Governor of Indiana.

Subject: *Public Health in Indiana.*

Entertainment: JOSEPH DUNNINGER.

*Thursday, November 8, 1945*

7:00 a.m. House of Delegates breakfast meeting, West Room, French Lick Springs Hotel. Annual election of officers and selection of convention city for 1946.

Meeting of Council immediately following adjournment of House of Delegates.

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## WOMEN'S ENTERTAINMENT

*Tuesday, November 6, 1945*

9:00 a.m. Registration, north porch, off main lobby, French Lick Springs Hotel.

2:30 p.m. Board meeting, Woman's Auxiliary to the Indiana State Medical Association, Radio Room, mezzanine floor, French Lick Springs Hotel.

7:00 p.m. Dinner and entertainment, Main Dining Room, French Lick Springs Hotel.

*Wednesday, November 7, 1945*

9:00 a.m. Annual Auxiliary breakfast meeting, west dining room, French Lick Springs Hotel.

Speaker: CREIGHTON BARKER, M.D., Executive Secretary, Connecticut State Medical Society, New Haven.

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## SCIENTIFIC EXHIBIT

*The Menace of the Rat*

American Medical Association

# OFFICIAL CALL TO THE HOUSE OF DELEGATES

The next annual session of the Indiana State Medical Association will be held at French Lick, November 6, 7, and 8, 1945.

The House of Delegates will be constituted as follows: Marion County, fourteen delegates; Lake County, five delegates; Allen County, four delegates; St. Joseph County, three delegates; Vanderburgh County, three delegates; Daviess-Martin, Dearborn-Ohio, Delaware-Blackford, Fayette-Franklin, Fountain-Warren, Jasper-Newton, Madison, Parke-Vermillion, Tippecanoe, Vigo, and Wayne-Union County societies, each two delegates; the other sixty-seven county societies, each one delegate; thirteen councilors; and the ex-presidents, namely: C. S. Bond, W. H. Stemm, W. R. Davidson, E. M. Shanklin, Charles N. Combs, George R. Daniels, Charles E. Gillespie, A. B. Graham, F. S. Crockett, J. H. Weinstein, E. E. Padgett, R. L. Sensenich, Herman M. Baker, E. M. VanBuskirk, Karl R. Ruddell, A. M. Mitchell, M. A. Austin, Carl H. McCaskey, and J. T. Oliphant. In addition to these, the president, secretary, and treasurer, all without power to vote except in case of a tie, when the president shall cast the deciding vote.

Blank credentials have been sent by the secretary to each county society, and the properly-executed credentials should be mailed to Thomas A. Hendricks, 1021 Hume Mansur Building, Indianapolis 4, or brought to the session. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 1:00 P.M., Tuesday, November 6, in the Main Convention Hall of the French Lick Springs Hotel. The House will meet again at 3:30 P.M., Tuesday, November 6, in the Main Convention Hall, to consider the report of the Committee on Prepayment of Medical and Surgical Care. The breakfast meeting of the House will be held at 7:00 o'clock Thursday morning, November 8, in the West Room of the French Lick Springs Hotel.

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Reading of the minutes of previous meetings.
4. Appointment of reference committees.
5. Report of executive secretary.
6. Report of the treasurer.
7. Report of the chairman of the council.
8. Reports of standing and special committees:
   (1) Credentials.
   (2) Executive Committee.
   (3) Arrangements.
   (4) Scientific Work.
   (5) Public Policy and Legislation.
   (6) Bureau of Publicity.
   (7) Civic and Industrial Relations.
   (8) Medical Education and Hospitals.
   (9) Council on Medical Service and Public Relations.
   (10) JOURNAL Publication.
   (11) Secretaries' Conference.
   (12) Prepayment of Medical and Surgical Care.
   (13) Necrology and History.
   (14) Physical Fitness.
   (15) Mental Health.
   (16) Study of Lay Activity in Medical Practice.
   (17) Advisory Committee to the Bureau of Maternal and Child Health of the Indiana State Board of Health.
   (18) Liaison Committee of the Division of Services for Crippled Children.
   (19) Auditing.
   (20) Control of Cancer.
   (21) Venereal Disease.
   (22) Industrial Health.
   (23) Indiana Inter-professional Health Council.
   (24) Anti-Tuberculosis.
   (25) Conservation of Vision.
   (26) War Participation.
   (27) Physical Therapy.
   (28) Medical Relief.
   (29) Rural Medical Care.
   (30) OPA Medical Advisory Committee.
   (31) Hard of Hearing.
   (32) Postwar Medical Service.
   (33) Medical Economics.
   (34) Rehabilitation Services.
   (35) Centennial Celebration.
9. Reading of Communications.
10. Reading of memorials and resolutions.
11. Unfinished business.
12. New business.
13. Adjournment.

The election of officers will be the first order of business at the last meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire December 31, 1945, and their successors must be elected at the session: Delegates to the American Medical Association to succeed Don F. Cameron, Fort Wayne, and F. S. Crockett, Lafayette; and alternates, Norman M. Beatty, Indianapolis, and A. M. Mitchell, Terre Haute.

Delegates from the second, fifth, eighth, and eleventh districts are reminded that the terms of their councilors will expire December 31, 1945, and new councilors should be elected to succeed the following:

Second District: H. C. Wadsworth, Washington.
Fifth District: A. M. Mitchell, Terre Haute.
Eighth District: E. H. Clauser, Muncie.
Eleventh District: C. S. Black, Warren.

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

THOMAS A. HENDRICKS,
*Executive Secretary.*

## HOUSE OF DELEGATES—INDIANA STATE MEDICAL ASSOCIATION

| Delegates | Alternates |
|---|---|
| **Adams** | |
| M. L. Habegger, Berne | J. M. Burk, Decatur |
| **Allen** | |
| M. B. Catlett, Ft. Wayne | C. B. Parker, Ft. Wayne |
| William Wright, Ft. Wayne | E. R. Carlo, Ft. Wayne |
| M. R. Lohman, Ft. Wayne | L. S. McKeeman, Ft. Wayne |
| A. H. Duemling, Ft. Wayne | H. V. Scott, Ft. Wayne |
| **Bartholomew** | |
| Lowell F. Beggs, Columbus | Joseph E. Dudding, Hope |
| **Benton** | |
| **Boone** | |
| R. J. Harvey, Zionsville | William H. Spieth, Lebanon |
| **Carroll** | |
| Max Adams, Flora | C. L. Wise, Camden |
| **Cass** | |
| E. B. Jewell, Logansport | John C. Davis, Logansport |
| **Clark** | |
| J. T. Carney, Jeffersonville | D. L. Carlberg, Jeffersonville |
| **Clay** | |
| J. Frank Maurer, Brazil | L. C. Rentschler, Clay City |
| **Clinton** | |
| **Crawford** | |
| **Daviess-Martin** | |
| C. P. Fox, Washington | I. E. Bowman, Odon |
| Karl Helm, Shoals | J. W. Strange, Loogootee |
| **Dearborn-Ohio** | |
| M. J. McNeely, Dillsboro | J. C. Elliott, Guilford |
| G. S. Fessler, Rising Sun | |
| **Decatur** | |
| I. M. Sanders, Greensburg | H. S. McKee, Greensburg |
| **DeKalb** | |
| **Delaware-Blackford** | |
| Clay A. Ball, Muncie | E. T. Cure, Muncie |
| Lall G. Montgomery, Muncie | T. R. Owens, Muncie |
| **Dubois** | |
| S. L. McKinney, Huntingburg | P. J. Blessinger, Jasper |
| **Elkhart** | |
| A. C. Yoder, Goshen | S. T. Miller, Elkhart |
| **Fayette-Franklin** | |
| F. B. Mountain, Connersville | L. N. Ashworth, Connersville |
| E. M. Glaser, Brookville | H. N. Smith, Brookville |
| **Floyd** | |
| C. E. Briscoe, New Albany | G. I. Polhemus, New Albany |
| **Fountain-Warren** | |
| J. Carl Freed, Attica | |
| **Fulton** | |
| A. E. Stinson, Rochester | |
| **Gibson** | |
| Carl Clark, Oakland City | O. T. Brazelton, Princeton |
| **Grant** | |
| R. W. Lavengood, Marion | L. H. Eshleman, Marion |
| **Greene** | |
| K. L. Hull, Bloomfield | H. B. Turner, Bloomfield |
| **Hamilton** | |
| C. M. Donahue, Carmel | R. F. Harris, Noblesville |
| **Hancock** | |
| Joseph L. Allen, Greenfield | L. B. Rariden, Greenfield |
| **Harrison** | |
| William E. Amy, Corydon | |
| **Hendricks** | |
| O. T. Scamahorn, Pittsboro | C. B. Thomas, Plainfield |
| **Henry** | |
| C. E. Canaday, New Castle | L. C. Marshall, Mt. Summit |
| **Howard** | |
| E. R. Clarke, Kokomo | H. M. Rhorer, Kokomo |
| **Huntington** | |
| G. M. Nie, Huntington | Harold Bonifield, Warren |
| **Jackson** | |
| L. H. Osterman, Seymour | L. W. Elsner, Seymour |
| **Jasper-Newton** | |
| R. H. Ruhmkorff, Goodland | Harry English, Rensselaer |
| W. G. Pippenger, Brook | George Van Kirk, Kentland |
| **Jay** | |
| George Cring, Portland | D. E. Spahr, Red Key |
| **Jefferson** | |
| **Jennings** | |
| D. W. Matthews, North Vernon | W. L. Grossman, North Vernon |
| **Johnson** | |
| Oran Province, Franklin | Walter Portteus, Franklin |
| **Knox** | |
| C. L. Boyd, Vincennes | William Schulze, Vincennes |
| **Kosciusko** | |
| O. H. Richer, Warsaw | G. N. Herring, Pierceton |
| **Lagrange** | |
| **Lake** | |
| C. M. Jones, Whiting | E. L. Schaible, Gary |
| G. L. Verplank, Gary | F. J. McMichael, Gary |
| P. Q. Row, Hammond | C. C. Brink, Gary |
| H. W. Eggers, Hammond | J. S. Niblick, East Chicago |
| C. R. Pettibone, Crown Point | D. F. McGuire, East Chicago |
| **LaPorte** | |
| Jon N. Kelly, LaPorte | L. A. Wilson, Michigan City |
| **Lawrence** | |
| Claude Dollens, Oolitic | B. A. Speheger, Bedford |
| **Madison** | |
| A. W. Elsten, Anderson | C. S. Wright, Anderson |
| A. T. Jones, Pendleton | H. E. Jones, Anderson |
| **Marion** | |
| E. F. Boggs, Indianapolis | James N. Collins, Indpls. |
| R. C. Beeler, Indianapolis | J. H. Stygall, Indianapolis |
| G. J. Garceau, Indianapolis | C. H. Jinks, Indianapolis |
| R. W. Lochry, Indianapolis | Roy V. Myers, Indianapolis |
| H. L. Foreman, Indianapolis | R. J. Masters, Indianapolis |
| J. M. Whitehead, Indianapolis | Paul Merrell, Indianapolis |
| E. V. Hahn, Indianapolis | O. E. Carter, Indianapolis |
| H. C. Ochsner, Indianapolis | A. G. Funkhouser, Indpls. |
| Russell A. Sage, Indianapolis | R. C. Ottinger, Indianapolis |
| Ernest Rupel, Indianapolis | T. B. Noble, Jr., Indianapolis |
| Walter P. Morton, Indpls. | E. F. Bloemker, Indianapolis |
| J. O. Ritchey, Indianapolis | H. W. Sigmond, Indianapolis |
| M. W. Manion, Indianapolis | Glenn C. Lord, Indianapolis |
| Rollin Moser, Indianapolis | Bert E. Ellis, Indianapolis |
| **Marshall** | |
| A. A. Thompson, Tyner | T. R. Possolt, Plymouth |
| **Miami** | |
| F. M. Lynn, Peru | S. D. Malouf, Peru |
| **Monroe** | |
| William Karsell, Bloomington | Naomi Dalton, Bloomington |
| **Montgomery** | |
| G. A. Collett, Crawfordsville | C. B. Parker, Wingate |
| **Morgan** | |
| Henri LeClaire, Martinsville | Charles Comer, Mooresville |
| **Noble** | |
| C. E. Munk, Kendallville | J. R. Nash, Albion |
| **Orange** | |
| C. E. Boyd, West Baden Springs | John Spears, Paoli |
| **Owen** | |

| *Delegates* | *Alternates* |
|---|---|
| **Parke-Vermillion** | |
| R. J. Moran, Rockville | J. R. Bloomer, Rockville |
| P. B. Casebeer, Clinton | S. C. Darroch, Cayuga |
| **Perry** | |
| N. A. James, Tell City | P. J. Coultas, Tell City |
| **Pike** | |
| L. R. Miller, Winslow | G. B. DeTar, Winslow |
| **Porter** | |
| John R. Frank, Valparaiso | John F. Take, Valparaiso |
| **Posey** | |
| **Pulaski** | |
| **Putnam** | |
| V. E. Wiseman, Greencastle | G. F. Parker, Greencastle |
| **Randolph** | |
| L. K. Phipps, Union City | Wayne Harmon, Lynn |
| **Ripley** | |
| George S. Row, Osgood | N. D. Moran, Versailles |
| **Rush** | |
| C. C. Atkins, Rushville | L. M. Green, Rushville |
| **St. Joseph** | |
| A. S. Giordano, South Bend | J. F. Murphy, South Bend |
| C. M. Sennett, South Bend | M. J. Thornton, South Bend |
| F. R. N. Carter, South Bend | J. V. Cassady, South Bend |
| **Scott** | |
| **Shelby** | |
| W. D. Inlow, Shelbyville | P. R. Tindall, Shelbyville |
| **Spencer** | |
| J. H. Barrow, Dale | C. L. Springstun, Chrisney |
| **Starke** | |
| J. F. DeNaut, Knox | C. R. Farabee, North Judson |

| *Delegates* | *Alternates* |
|---|---|
| **Steuben** | |
| G. N. Lake, Pleasant Lake | P. A. Blosser, Fremont |
| **Sullivan** | |
| J. R. Crowder, Sullivan | C. E. Whipps, Carlisle |
| **Switzerland** | |
| L. H. Bear, Vevay | G. W. Copeland, Vevay |
| **Tippecanoe** | |
| Earl Van Reed, Lafayette | O. L. McCay, Romney |
| G. A. Thomas, Lafayette | R. R. Calvert, Lafayette (in service) |
| **Tipton** | |
| S. M. Cotton, Goldsmith | A. E. Stouder, Kempton |
| **Vanderburgh** | |
| Minor Miller, Evansville | C. W. Cullnane, Evansville |
| Robert R. Acre, Evansville | |
| **Vigo** | |
| M. C. Topping, Terre Haute | A. W. Cavins, Terre Haute |
| E. O. Nay, Terre Haute | W. C. Kunkler, Terre Haute |
| **Wabash** | |
| O. G. Brubaker, North Manchester | |
| **Warrick** | |
| **Washington** | |
| **Wayne-Union** | |
| Harry P. Ross, Richmond | E. E. Holland, Richmond |
| Will A. Thompson, Liberty | W. B. McWilliams, Liberty |
| **Wells** | |
| Harold D. Caylor, Bluffton | H. Brooks Smith, Bluffton |
| **White** | |
| **Whitley** | |
| P. A. Garber, South Whitley | P. Huffman, South Whitley |

## FRENCH LICK SPRINGS HOTEL RATES

Single room with bath, occupied by one—$13.00 per day, each.

Double rooms with twin beds and bath in the deluxe section and in main and front section overlooking the gardens—$11.00 per day, per person, when occupied by two.

Double rooms with bath in the old section on back of house—$10.00 per day, per person when occupied by two.

Single rooms with lavatory and toilet, occupied by one—$10 per day, each.

Double rooms with lavatory and toilet—$9.00 per day, per person when occupied by two.

Rooms with running water only—$8.00 per day, per person whether occupied by one or two.

Room rates include all meals and special convention banquet. The charges are to be divided into quarter days so there will be no charges for anything not actually received, and based on the following periods:

*Arrival*—

Before 9:30 A.M.—full day.

After 9:30 A.M., before 2:30 P.M.—¾ day.

After 2:30 P.M., before 9:00 P.M.—½ day.

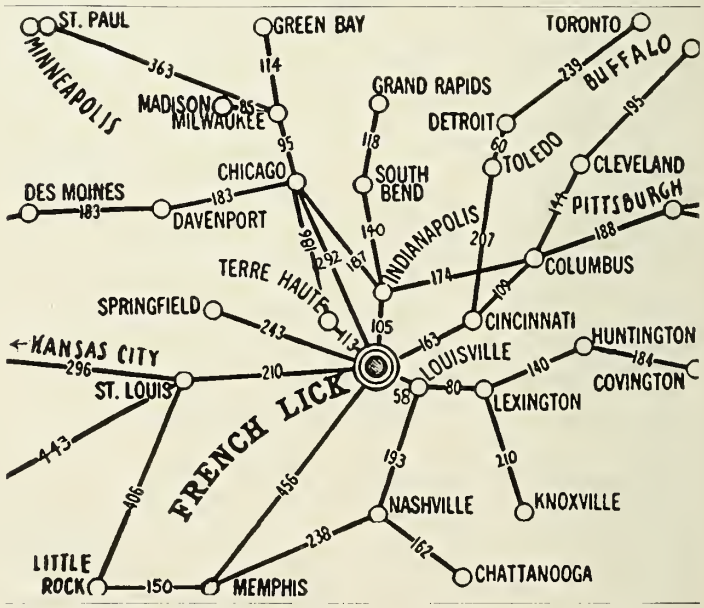
After 9:00 P.M.—¼ day.

*Departure*—(Means actual time of leaving, baggage out, rooms released.)

After 7:00 A.M., before 11:00 A.M.—¼ day.

After 11:00 A.M., before 4:00 P.M.—½ day.

After 9:00 P.M.—full day.



# COMMITTEES FOR FRENCH LICK CONVENTION

**COMMITTEE ON CONVENTION ARRANGEMENTS:** Co-chairmen, August P. Hauss, New Albany, and Clarence E. Boyd, West Baden; C. E. Briscoe, New Albany; E. P. Buckley, Jeffersonville; P. R. Pierson, New Albany; Marvin McClain, Scottsburg; Novy E. Gobbel, English; J. Y. McCullough, New Albany; H. R. Wilber, Jeffersonville.

**RECEPTION COMMITTEE:** Chairman, P. R. Pierson, New Albany; H. L. Miller, West Baden Springs; N. E. Gobbel, English; Claude Dollens, Oolitic; W. E. Amy, Corydon; Dudley F. Davis, New Albany; Roland E. Wynne, Bedford; J. P. Wilson, Scottsburg; I. E. Huckleberry, Salem.

**REGISTRATION COMMITTEE:** Chairman, C. E. Boyd, West Baden Springs; P. J. Blessinger, Jasper; Marvin McClain, Scottsburg; Philip Cohn, New Albany; H. H. Deen, Leavenworth; J. J. Johnson, Milltown; Jesse Benz, Marengo; Henry G. Backer, Ferdinand; John R. Pearson, Bedford; William Green, Pekin.

**MILITARY RECEPTION COMMITTEE:** Chairman, Lieutenant Colonel William H. Garner, New Albany; Major George Dillinger, French Lick; Major Samuel Baxter, New Albany; Major William F. Edwards, New Albany; Captain James W. Baxter, Jr., New Albany.

**WOMEN PHYSICIANS:** G. Irene Polhemus, New Albany.

**STAG PARTY COMMITTEE:** Chairman, Ernest P. Buckley, Jeffersonville; Carl R. Bogardus, Austin; Harold R. Wilber, Jeffersonville.

**GOLF TOURNAMENT COMMITTEE:** Chairman, Herbert P. Sloan, New Albany; H. B. Shacklett, New Albany; J. T. Carney, Jeffersonville; A. R. Oleck, New Albany.

**TRAP SHOOT COMMITTEE:** Chairman, John K. Spears, Paoli; H. K. Engleman, Georgetown; Frank T. Tyler, New Albany; George H. Day, New Albany.

**LANTERN COMMITTEE:** Chairman, W. E. Schoolfield, Orleans; A. E. Newland, Bedford; R. P. Austin, Bedford.

**BANQUET COMMITTEE:** Chairman, Martin B. Strange, New Albany; Sherman L. McKinney, Huntingburg; LaFayette Glenn, Ramsey; J. Y. McCullough, New Albany; Ralph W. Bruner, Jeffersonville.

**FRATERNITY AND CLASS REUNION COMMITTEE:** Chairman, Harry E. Voyles, New Albany; Morrel E. Simpson, Bedford; David G. Pryor, Jeffersonville; Carl E. Dillman, Corydon.

**WOMEN'S ENTERTAINMENT COMMITTEE:** Chairman, Mrs. James W. Baxter, Jr., New Albany; Mrs. A. M. Baker, New Albany; Mrs. A. P. Hauss, New Albany; Mrs. Samuel Baxter, New Albany; Mrs. C. E. Boyd, West Baden; Mrs. George Dillinger, French Lick; Mrs. H. L. Miller, West Baden; Mrs. Ivan Clark, Paoli; Mrs. J. K. Spears, Paoli; Mrs. Keith Hammond, Paoli; Mrs. R. E. Baker, Orleans; Mrs. W. E. Schoolfield, Orleans; Mrs. G. G. Colglazier, Leipsic; Mrs. Marvin McClain, Scottsburg; Mrs. E. P. Buckley, Jeffersonville; Mrs. C. E. Briscoe, New Albany; Mrs. N. E. Gobbel, English; Mrs. J. Y. McCullough, New Albany; Mrs. H. R. Wilber, Jeffersonville; Mrs. P. R. Pierson, New Albany.

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# REFERENCE COMMITTEES—1945

**1. SECTIONS AND SECTION WORK:**

Chairman, C. P. Fox, Washington (Daviess-Martin)
C. S. Fessler, Rising Sun (Dearborn-Ohio)
I. M. Sanders, Greensburg (Decatur)
Carl Clark, Oakland City (Gibson)
A. T. Jones, Pendleton (Madison)

**2. RULES AND ORDER OF BUSINESS:**

Chairman, C. R. Pettibone, Crown Point (Lake)
William Wright, Fort Wayne (Allen)
S. M. Cotton, Goldsmith (Tipton)
Will A. Thompson, Liberty (Wayne-Union)
Herman M. Baker, Evansville (Vanderburgh)

**3. MEDICAL EDUCATION AND HOSPITALS:**

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Harold D. Caylor, Bluffton (Wells)
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Chairman, H. W. Eggers, Hammond (Lake)
E. Vernon Hahn, Indianapolis (Marion)
F. M. Lynn, Peru (Miami)
C. E. Briscoe, New Albany (Floyd)
E. O. Nay, Terre Haute (Vigo)

**5. PUBLICITY:**

Chairman, Gordon A. Thomas, Lafayette (Tippecanoe)
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John R. Frank, Valparaiso (Porter)
L. R. Miller, Winslow (Pike)
Ralph W. Lochry, Indianapolis (Marion)

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R. J. Harvey, Zionsville (Boone)
Clay Ball, Muncie (Delaware-Blackford)
C. M. Donahue, Carmel (Hamilton)
E. R. Clarke, Kokomo (Howard)

**7. AMENDMENTS TO CONSTITUTION AND BY-LAWS:**

Chairman, J. H. Weinstein, Terre Haute (Vigo)
M. B. Catlett, Fort Wayne (Allen)
Max Adams, Flora (Carroll)
C. E. Canaday, New Castle (Henry)
J. T. Carney, Jeffersonville (Clark)

**8. REPORTS OF OFFICERS:**

Chairman, G. A. Collett, Crawfordsville (Montgomery)
P. Q. Row, Hammond (Lake)
Harry P. Ross, Richmond (Wayne-Union)
F. R. N. Carter, South Bend (St. Joseph)
R. C. Beeler, Indianapolis (Marion)

**9. COMMITTEE ON CREDENTIALS:**

Chairman, A. E. Stinson, Rochester (Fulton)
Rollin Moser, Indianapolis (Marion)
N. A. James, Tell City (Perry)
Jon N. Kelly, LaPorte (LaPorte)
J. Frank Maurer, Brazil (Clay)

**10. COMMITTEE ON MISCELLANEOUS BUSINESS:**

Chairman M. R. Lohman, Fort Wayne (Allen)
E. B. Jewell, Logansport (Cass)
A. C. Yoder, Goshen (Elkhart)
F. B. Mountain, Connersville (Fayette-Franklin)
K. L. Hull, Bloomfield (Greene)

# ANNUAL INDIANA HEALTH OFFICERS' CONFERENCE

FRENCH LICK SPRINGS HOTEL

FRENCH LICK, INDIANA

November 5, 1945

## PROGRAM

**Afternoon:**

12:00-1:30 p.m. Registration.

1:30-2:00 p.m. "Plans of the State Board of Health." L. E. Burney, M.D., State Health Commissioner.

2:00-2:30 p.m. Address, President, Indiana Health Officers Association.
F. R. Nicholas Carter, M.D.

2:30-2:50 p.m. "The Emergency Maternal and Infant-Care Program."
Robert E. Jewett, M.D., Director, Division of Maternal and Child Health.

2:50-3:10 p.m. "Preliminary Plans for a Dental Health Program."
L. M. Childers, D.D.S., Director, Division of Dental Health.

3:10-3:30 p.m. "Progress in Tuberculosis Control."
Holland Thompson, M.D., Director, Division of Tuberculosis Control.

3:30-4:00 p.m. "Hospital Licensure."
Robert E. Jewett, M.D.

4:00-4:20 p.m. "Problems in Venereal Disease Control."
George Bowman, M.D., Director, Division of Venereal Disease Control.

4:20-4:45 p.m. "Assistance to Health Officers in Health Education."
Robert Yoho, Director, Division of Health and Physical Education.

**Evening:**

7:00 p.m. Dinner Meeting.
(Address by speaker to be announced later.)

# Announcements

### LADIES AND GENTLEMEN!

The Orange County Medical Society and the Third District Medical Society have planned a gala affair for you at the French Lick Springs Hotel. Let's make this an all-out Victory meeting.

### TRAP SHOOT

The traps at the French Lick Gun Club have temporarily been dismantled, but if you want to shoot, we may be able to arrange a trap shoot at the club in Orleans. Send in your entry now to Dr. John K. Spears, Paoli, Indiana. We will notify you later if the shoot is on.

TRAP SHOOT COMMITTEE
John K. Spears, Paoli, *Chairman*,
H. K. Engleman, Georgetown,
Frank T. Tyler, New Albany,
George H. Day, New Albany.

### WAR PARTICIPATION COMMITTEE LUNCHEON

A luncheon meeting for the War Participation Committee will be held in the Main Dining Room, French Lick Springs Hotel, on Wednesday, November 7, 1945, with Charles R. Bird, M.D., Chairman of the Procurement and Assignment Service for Indiana, presiding. Everyone is invited. Tables will be reserved for fraternities, classes, and special groups. Major General George F. Lull, United States Army, and Deputy Surgeon General, Washington, D.C., will talk on "Repercussions"; and Watson B. Miller, Federal Security Administrator, Washington, D. C., will present "The Medical Profession Today and Tomorrow."

### INDIANA MEDICAL COLLEGE CLASS OF 1907

Members of the Indiana Medical College class of 1907 wishing a place at the '07 table for luncheon on Wednesday, November 7, please inquire at the registration desk.

## Auxiliary Members, Attention, Please!

**To the members of The Woman's Auxiliary to The Indiana State Medical Association, and to all doctors' wives in the state, we extend a most cordial invitation to attend the convention at French Lick, November 6, 7, and 8. The war is over, and although there is still work to be done, we are planning a program of relaxation and enjoyment for all. Plan now to meet us in French Lick!**

COMMITTEE, AUXILIARY ACTIVITIES

# SUPPLEMENTARY REPORT OF VENEREAL DISEASE COMMITTEE OF THE INDIANA STATE MEDICAL ASSOCIATION

**The interpretation of serologic reports with special reference to discharged service men, but applicable to all cases of doubtful serologic reports in which an interpretation must be made before treatment is instituted.**

The results of doubtful and/or positive serologic tests for syphilis made routinely at service centers are unknown to the serviceman at the time of his discharge unless he has an infectious syphilis, at which time he is, of course, held for presumably minimum adequate treatment. Without any clinical manifestations, he is discharged, but such reports are forwarded later to the Division of Venereal Disease Control of the Indiana State Board of Health with such data and the amount of treatment or none, and the results of blood and spinal fluid tests. These reports are channeled by the State Board of Health through local health officers in the separatee's home community. The communication of such results, particularly separatees who have had malaria, to the patient or their families will be a source of worry and some difficulty in personal and family relations. The results of such tests when not supported by objective clinical manifestations by history, and without previous treatment, must be interpreted with caution.

The possibility of both technical error and biologic false positive reactions must be constantly kept in mind. Doubtful and false positive reactions may occur in a number of diseases, such as acute infections, but particularly malaria, infectious mononucleosis, infectious hepatitis, as well as some of the other tropical diseases. With the large number of individuals in the military services who have had malaria, doubtful or false positive tests usually occur when the disease is manifested by clinical activity or the presence of parasites in the blood. Such tests are usually found to be only weakly positive when quantitative results are available, and are usually transient. The Committee for the Control of Venereal Diseases, of the Indiana State Medical Association, and the Division of Venereal Disease Control, of the Indiana State Board of Health, feel that treatment should not be instituted in these cases until blood specimens have been rechecked over a sufficiently long time to confirm the diagnosis of syphilis.

Again, it must not be forgotten that a doubtful test at separation may be evidence of a beginning early new syphilis.

The treatment for syphilis should not be initiated without an established diagnosis after study of the individual case. Great care should be exercised in the communication of the results of tests to others.

Submitted by:

VENEREAL DISEASE COMMITTEE,
INDIANA STATE MEDICAL ASSOCIATION

F. R. N. CARTER, M.D., *Chairman.*
C. E. CANADAY, M.D.
W. W. HEWINS, M.D.
W. P. MORTON, M.D.
E. O. NAY, M.D.
R. G. MOORE, M.D.
MINOR MILLER, M.D.
J. S. REYNOLDS, M.D.
ERNEST RUPEL, M.D.
GEORGE W. BOWMAN, M.D.
T. B. HAYES, M.D.

Approved by:

GEORGE W. BOWMAN, M.D.,
*Director, Division of Venereal Disease Control.*

CLYDE G. CULBERTSON, M.D.,
*Director, Bacteriological Laboratory, Indiana State Board of Health.*

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## A. M. A. HOUSE OF DELEGATES TO CONVENE IN CHICAGO ON DECEMBER 3

The annual meeting of the House of Delegates, the policy-making body of the American Medical Association, will be held in Chicago for four days, beginning December 3, according to an announcement in the September 22 issue of *The Journal of the American Medical Association.*

The annual session, usually held in June, but delayed this year because of wartime travel restrictions, was called by Herman L. Kretschmer, M.D., Chicago, President of the A.M.A., and H. H. Shoulders, M.D., Nashville, Tenn., Speaker of the House of Delegates. The meeting, which will be held in the Palmer House, is expected to bring together approximately two hundred delegates and officials of the association, coming from all parts of the country.

During the session Doctor Kretschmer will relinquish the presidency of the association, and will be succeeded by Roger Irving Lee, M.D., of Boston, who was chosen president-elect at the wartime session of the A.M.A., which was held in Chicago in June, 1944.

Olin West, M.D., Secretary of the American Medical Association, said that the December session of the House of Delegates would be devoted to consideration of many problems of great significance for the future of medical practice. "The House," he said, "will consider many questions related to medical services and establish policies for the medical profession. The association is devoted to the maintenance of a high quality of medical service, a high standard of medical education, and a wider distribution of good medical care to all the people."

Because of the war, the annual A.M.A. convention could not be held in New York this year. A wartime session, attended by more than seven thousand, was held in Chicago last year. San Francisco was selected some years ago to play host to the June, 1946, convention.

# Exhibitors

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## MEAD JOHNSON & COMPANY

**Evansville, Ind.**

"Servamus Fidem" means, "We are Keeping the Faith." Almost every physician thinks of Mead Johnson & Company as the maker of Dextri-Maltose, Pablum, Oleum Percomorphum, and other infant diet materials—including the new precooked oatmeal cereal, Pabena. But not all physicians are aware of the many helpful services this progressive company offers physicians. A visit to Booth No. 3 will be time well spent.

*Booth 4*

## SCHERING CORPORATION

**Bloomfield, New Jersey**

Presented are the purest and most potent hormones available, products which have set the standard in modern endocrine therapeutics. Selected specific chemotherapeutic agents and the products which are effective as diagnostic roentgenographic and cholecystographic substances are displayed. The result of major scientific research, and based upon objective clinical observations, products of Schering Corporation, Bloomfield, New Jersey, are displayed, together with charts and graphic material designed to assist the practicing physician.

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*Booth 5*

## E. R. SQUIBB & SONS

**New York City**

A scientific exhibit presenting pertinent data on new penicillin products, Intocostrin and nutritive therapy.

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*Booth 6*

## CAMEL CIGARETTES

**New York City**

Camel Cigarettes will exhibit a large detailed photograph showing the calculated absorption of nicotine from cigarette smoke in the human respiratory tract. Representatives will be on hand to discuss any phase of the physiological effects of smoking

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*Booth 7*

## C. B. FLEET COMPANY

**Lynchburg, Virginia**

Phospho-Soda (Fleet), a saline eliminant, an ethical product for over half a century.

What may you, as a physician, expect from this stable, non-toxic concentrate of the two U.S.P. sodium phosphates?

1. Accurate dosage, regulated to the patient and to his condition.
2. The maximum therapeutic effectiveness of sodium phosphate.
3. Quick, gripeless evacuation, for emergencies.
4. Mild, controllable elimination, for chronic biliary disturbance or constipation.
5. Unusual freedom from after-irritation, with normalizing buffer action.
6. Safe action with administration of the sulfonamides.

Are you getting the full value of medication in your daily problems of elimination?

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*Booth 8*

## FREDERICK STEARNS & COMPANY DIVISION

**Detroit, Mich.**

You are cordially invited to visit the exhibit of Frederick Stearns & Company Division. Neo-Synephrine Hydrochloride products for intranasal, parenteral and ophthalmic use will be featured. Parenamine (Amino Acids, Stearns) for preventing and correcting protein deficiency by parenteral or oral administration; Fergon, a better tolerated, better utilized ferrous salt; and other Professional Specialties developed by the Stearns Research Laboratories will also be shown. Members of our professional staff will be in attendance to discuss these distinctive products with you.

*Booth 9*

**HOLLAND-RANTOS COMPANY, INC.**

**New York Chicago Los Angeles**

You are cordially invited to visit the Holland-Rantos booth where on display will be the nationally-known and universally-used Koromex contraceptive specialties. Besides the new Koromex Set Complete, which is a package combining the necessary items for complete contraceptive technique, will be the new Nylmerate Jelly introduced only a short time ago and received enthusiastically for the treatment of trichomoniasis and vaginal discharges of a non-specific origin.

Representatives of the company will be on hand to answer all questions. Samples of Nylmerate Jelly and Koromex Jelly will be available, as will copies of the Dickinson Freret Charts.

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*Booths 10 and 11*

**SCHENLEY LABORATORIES, INC.**

**Executive Offices—350 Fifth Avenue, N. Y. C.**

The Schenley Laboratories exhibit is devoted entirely to penicillin. A series of transilluminated Kodachromes shows the magnitude of this company's manufacturing laboratories and the care taken in testing the product to maintain sterility, potency, and freedom from pyrogens. A well-informed attendant will gladly discuss any phase of penicillin therapy and developments with interested physicians.

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*Booth 12*

**ELI LILLY AND COMPANY**

**Indianapolis**

The Lilly exhibit is presented as a mark of respect for the Indiana State Medical Association. Many Lilly products will be shown, and the attending medical service representatives will be pleased to aid physicians whenever possible.

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*Booths 13 and 14*

**PITMAN-MOORE COMPANY**

**Indianapolis, Ind.**

The Pitman-Moore exhibit will feature, in a most attractive, animated setting, a number of the Company's well-known products. Company executives from the laboratories at Indianapolis and Zionsville, as well as Indiana sales representatives, will be on hand to greet their friends in the profession, and to answer questions concerning the Company's products.

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*Booth 15*

**DAIRY COUNCILS OF INDIANA**

Stop at the "Milk Bar" of the Dairy Councils of Indiana for your copy of the "Newer Knowledge of Milk." This booklet contains scientific information on milk, and in addition a concise review of the latest information on amino acids, minerals, and vitamins. Other health education materials which you will want to give to your patients will also be on display.

The exhibit is sponsored by the Dairy Councils of Elkhart, Evansville, Fort Wayne, Indianapolis, Kokomo, and South Bend.

These units are affiliated with the National Dairy Council of Chicago, Illinois, which is the health educational organization of the dairy industry. The services of the Dairy Councils and their materials are free of charge.

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*Booth 16*

**VAN AUSDALL & FARRAR**

**Indianapolis, Ind.**

Ediphone Voicewriting Instruments, manufactured by Thomas A. Edison, Incorporated, will be presented by Van Ausdall & Farrar, Indiana Distributors, with offices at Indianapolis, Evansville, and Fort Wayne. This exhibit will be featured by Edison's new postwar Electronic instruments, the Mercury and the Director. True fidelity voice recording, so important for the use of medical terms, now becomes available to the physician and surgeon. Mr. C. F. Farrar and Mr. J. A. Shields will be on hand in Exhibit No. 16 to demonstrate these instruments to you.

*Booth 17*

**W. B. SAUNDERS COMPANY**

**Philadelphia**

This publishing house will exhibit its complete line of books. Included among the new and important books to be shown are: Bockus' 3-volume work on "Gastro-enterology"; new (5th) edition of Beckman's "Treatment"; new (4th) edition of Christopher's "Textbook of Surgery"; new (4th) edition of Mitchell & Nelson's "Pediatrics"; Ash & Spitz' "Atlas of Pathology of Tropical Medicine"; Jackson & Jackson's "Diseases of the Nose, Throat and Ear"; Jones & Shepard's "Manual of Surgical Anatomy"; Moorhead's "Clinical Traumatic Surgery"; Herrell's "Penicillin"; Wohl's "Dietotherapy"; Haymaker & Woodhall's "Peripheral Nerve Injuries"; "Manual of Tropical Medicine"; Janney's "Medical Gynecology"; 3rd edition of Levine's "Clinical Heart Disease"; "Manual of Mycology"; 3rd edition of Stokes, Beerman & Ingraham's "Syphilology"; Orr's "Operations of General Surgery"; Pullen's "Medical Diagnosis," and many others.

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*Booth 18*

**CIBA PHARMACEUTICAL PRODUCTS, INC.**

**Summit, New Jersey**

Physicians are cordially invited to attend the display of Ciba products at Booth No. 18.

The potent androgenic hormones, Perandren and Metandren, will receive prominent attention. Metandren Linguets will be particularly featured because of their economy and effectiveness in use. Privine, a powerful vasonasal constrictor of particularly prolonged action, will also occupy an outstanding position. Of particular interest to surgeons will be Nupercaine, which can be used for prolonged spinal anesthesia, according to the technique recently described by Adriani. (Surgery, April, 1945.) Reprints of this instructive report will be available to all interested. New forms of the synthetic antispasmodic, Trasentine, namely ampuls and suppositories, will merit the attention of all classes of physicians. Other outstanding Ciba products which will be on exhibit will include the powerful analeptic, Coramine, the nonirritating antiseptic and trichomonacide, Vioform, and the liver-fortified Vitamin B preparation, Biotose.

Representative in charge: Mr. Howard Bilden.

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*Booth 19*

**AYERST, McKENNA & HARRISON LIMITED**

**Rouses Point, N. Y. Montreal, Canada**

"Premarin", a highly potent, naturally-occuring complex of conjugated estrogens, will be featured.

"Premarin" constitutes a recent advance in endocrine research, resulting from the collaboration of Dr. J. B. Collip, Director of the Research Institute of Endocrinology, McGill University, with our laboratories, and is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

We shall also display two new pertussis preparations, one for prophylaxis and the other for treatment of the active stages of whooping cough. These are based on the principle that the endotoxin of the H. pertussis organism is important in the etiology of the disease.

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*Booth 20*

**THE PROCTER & GAMBLE COMPANY**

**Ivorydale, Ohio**

Procter & Gamble—the manufacturers of world-famous Ivory Soap—will have Exhibit No. 20. Included in the booth are illuminated color pictures of various techniques used in studying mildness of soaps. Copies of Ivory's popular booklet "Bathing Your Baby The Right Way," and samples of Ivory Soap will be given to all members.

*Booth 22*

**WHITE LABORATORIES, INC.**

**Newark, New Jersey**

White Laboratories, Inc., at Booth No. 22, present information regarding White's Sulfathiazole Gum—expressly formulated for topical chemotherapy in oropharyngeal infections.

White's Otomide, a new and more effective means of topical chemotherapy in ear infections, is offered for discussion.

White's ethically-promoted vitamin specialties are also featured.

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*Booth 23*

**A. S. ALOE COMPANY**

**St. Louis, Missouri**

A. S. Aloe Company, Booth No. 23, will show a number of new postwar specialties for the physician, as well as a cross section of their complete line of American-made stainless steel surgical instruments. Aloe Indiana representatives on hand to welcome the attending physicians will be E. P. Garson, George E. Lukemeyer, and E. L. Rattner.

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*Booth 24*

**H. J. HEINZ COMPANY**

**Pittsburgh, Pennsylvania**

H. J. Heinz Company is displaying and sampling their Strained and Junior Foods. The latest addition to this line is Heinz Pre-Cooked Cereal Food, a new easily-prepared toasted Cereal. It contains wheat, corn, and oats, together with wheat germ and corn germ. For further enrichment di-calcium phosphate, calcium carbonate, and vitamin B complex have been added. Their representatives would appreciate your suggestions and remarks about these products.

They are presenting a new publication, "The Nutritive Value of Vegetables." Examine, then register for it. A reminder—if desired, also register for the 11th edition "Nutritional Chart, Nutritional Observatory, Special Dietary Foods Book," and an office supply of "Your Baby's Diary and Calendar."

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*Booth 25*

**THE BORDEN COMPANY**

**New York**

Spend a friendly few minutes with The Borden Company at Booth No. 25, and leisurely refresh your memory of our Prescription Products! Renew your acquaintanceship with Biolac, the complete infant food—just dilute with water, no more, no less (supplement with vitamin C) . . . New Improved Dryco, with high protein and low fat for formula flexibility, an ideal infant food in all feeding cases . . . Mull-Soy, the hypo-allergenic soy food for your milk allergic patients, young or old . . . powdered whole milk Klim . . . the improved milk-sugar Beta Lactose, particularly important in many infont formulas . . . and the Merrell-Soule Protein and Lactic Acid Milks, especially helpful in those baffling diarrhea cases and celiacs.

Fred W. Rogers, who has called on Indiana physicians for many years, will be on hand to greet you.

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*Booth 26*

**SPENCER, INCORPORATED**

**New Haven, Connecticut**

You are cordially invited to visit our exhibit, featuring Spencer Individually Designed Supports for abdomen, back, and breasts. Doctors will be especially interested in these supports for patients who have undergone mastectomy. They will also be interested in the Spencer Spinal Support for patients following cast removal, or as an aid to treatment of ruptured disc and other back derangements. Supports for patients with hernia, visceroptosis with symptoms, postoperative needs, obesity, and prenatal and postpartum needs are also on display.

*Booth 27*

**THE DOHO CHEMICAL CORPORATION**

**New York London Montreal**

The Doho Chemical Corporation, 58 Varick Street, New York City, Makers of Auralgan, are introducing a new sulfa drug for treatment and control of chronic suppurating ears, Otosmosan.

Colored Lantern Slides and moulage models depicting acute and pathological conditions of the ear, with strict scientific accuracy, so as to be highly constructive and interesting to all physicians, will be displayed at this exhibit.

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*Booth 28*

**PHILIP MORRIS & COMPANY, LTD., INC.**

**New York City**

Philip Morris & Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

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*Booth 29*

**THE WARREN-TEED PRODUCTS COMPANY**

**Columbus, Ohio**

The Warren-Teed Products Company—manufacturers of a complete line of ethical pharmaceuticals—will have on display several of their newest medicaments which have been developed by their research department and announced during the past year or two.

They will also exhibit an equal number of outstanding products which physicians have been prescribing for years—products on which the reputation and steady growth of this organization has been founded. The Warren-Teed representatives who cover various parts of the state will be in attendance at Warren-Teed's new, attractive, white display in Booth No. 29.

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*Booth 30*

**THE MEDICAL PROTECTIVE COMPANY**

**Fort Wayne, Indiana**

The Medical Protective Company is represented at Booth No. 30, where you are invited to call. Medical Protective service is an institution of the medical profession, whose legal liability problems we have concentrated upon for forty-six years. Bring your professional liability questions and problems to Booth No. 30. Our representative is at your service to present our protection plan, to explain the peculiar relation of the doctor to the law which governs your practice, or to discuss any particular phase of Professional Liability in which you are especially interested.

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*Booth 31*

**CAMERON SURGICAL SPECIALTY COMPANY**

**Chicago, Illinois**

All Cameron Surgical Units immediately available and on display. See the new Cameron Coagulo-Sigmoidoscope, Electro Diagnostosets, Bronchoscopes, Esophagoscopes, Laryngoscopes, Mirrolite, Binocular Prism Loupe, Magniscope, and other specialties developed for your postwar diagnosis, treatment, and surgery.

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*Booth 33*

**SHARP & DOHME, INCORPORATED**

**Philadelphia, Pennsylvania**

Sharp & Dohme will have their display at Booth No. 33, featuring Tyrothricin Concentrate for human use; "Lyovac" Normal Human Plasma; Sulfamerazine; "Sulfasuxidine"; "Caligesic" Ointment, a greaseless anesthetic and analgesic ointment which possesses specific antipruritic action; and "Prothricin", a new antibiotic nasal decongestant. A cordial welcome awaits all visitors.

*Booth 35*

**AMES COMPANY, INC.**

**Elkhart, Ind.**

Demonstrating new technics for qualitative detection of urine-sugar and albumin.

The Clinitest tablet method for detection of urine-sugar is a simple, reliable test for use by the diabetic patient and in the laboratory—the tablet reagent develops its own heat inside the test tube, eliminating the need for burners or other equipment.

The new Ames tablet test for urine-albumin gives the physician, technician, and public health worker a reliable nonpoisonous, noncorrosive reagent tablet, and does not require the use of heat.

*Booth 37*

**THE MALTINE COMPANY**

**New York City**

The Maltine Company, New York (Booth No. 37), is exhibiting the old as well as the new. Such fine products as Maltine with Cod Liver Oil, Malto-Yerbine and Neoferrum have enjoyed favorable recognition for many years. They have been joined by Tedral, Proloid, Depancol, and other developments of The Maltine Company's research laboratories. A cordial invitation is extended to you to visit Booth No. 37, where descriptive literature and samples are available.

*Booth 39*

**THE ALKALOL COMPANY**

**Taunton, Massachusetts**

The Alkalol Co. will exhibit two famous preparations: Alkalol a carefully balanced alkaline, saline solution aqueous, with no glycerine and only a trace of alcohol, that is used in the treatment of mucous membranes and irritated tissue; and Irrigol, a non-toxic alkaline, saline douche powder.

The representatives in charge are Mr. Floyd L. Cross and Mr. Carroll L. Bristol.

*Booth 41*

**ABBOTT LABORATORIES**

**North Chicago**

With peace comes your opportunity to become better acquainted with a number of war-born scientific advances.

Here our Abbott-trained representatives will be glad to discuss a variety of these with you, especially the selection of Penicillin products on display.

Be sure to visit the Abbott Booth.

*Booth 42*

**AMERICAN HOSPITAL SUPPLY CORPORATION**

**Chicago, Illinois**

Baxter Intravenous Solutions and Equipment for collection and transfusion of whole blood will be a feature of the booth of the American Hospital Supply Corporation. In addition, Plasma and Serum preparation and infusion equipment will be on display. Solutions in the famous Baxter Vacoliters will be shown, along with such transfusion equipment as Transfuso-Vacs, Plasma Vacs, and Centri-Vacs. A trained staff will be in attendance to explain the newest in equipment and to answer questions on all phases of the Baxter Intravenous Technique.

Also on display will be many specialty items of importance to better hospital routine and service.

*Booth 43*

**CURTIS AND FRENCH**

**Indianapolis, Ind.**

Curtis and French, 510 North Capitol Avenue, Indianapolis 4, Indiana, will have on display for your inspection the latest nationally-known lines of equipment and instruments. Jack Curtis and Ed Clark will be in the booth to assist you.

*Booth 46*

**ORTHO PHARMACEUTICAL CORPORATION**

**Linden, New Jersey**

Ortho's exhibit will feature their council-approved products for the control of conception. Their physician's book "Medical Methods for the Control of Conception," as well as other literature and reprints, will be available.

Also exhibited will be other Ortho Gynecic Pharmaceuticals: Hexital— for the menopause; Hexestrol—the non-toxic oral estrogen; Nutri-Sal—for selected infertility cases; Aci-jel —for vaginal therapy.

*Booth 48*

**NATIONAL LIVE STOCK AND MEAT BOARD**

**Chicago, Illinois**

You are cordially invited to visit the National Live Stock and Meat Board exhibit. Nutrition literature, including material for an elementary school nutrition program, will be displayed.

VICTORY LOAN

"They finished their job . . . let's finish ours!"

Buy Victory Bonds to help pay for bringing our men home.

# PREPAYMENT OF MEDICAL AND SURGICAL CARE

MINUTES OF THE MEETING OF THE COMMITTEE ON PREPAYMENT OF MEDICAL AND SURGICAL CARE OF THE INDIANA STATE MEDICAL ASSOCIATION, COLUMBIA CLUB, INDIANAPOLIS, INDIANA

**September 9, 1945**

Meeting called to order at 10:20 A. M., by W. U. Kennedy, M.D., New Castle, chairman.

*Roll call:*

* W. U. Kennedy, New Castle, Chairman.
* Robert R. Acre, Evansville.
C. Philip Fox, Washington.
* Claude Dollens, Oolitic.
* I. M. Sanders, Greensburg.
M. C. Topping, Terre Haute.
* Joseph L. Allen, Greenfield.
* Marlow W. Manion, Indianapolis.
Bruce W. Stocking, Muncie.
* Wemple Dodds, Crawfordsville.
* J. Robert Doty, Gary.
* G. M. Nie, Huntington.
* J. R. Nash, Albion.
* F. R. N. Nicholas Carter, South Bend.
Robert M. Masters, Indianapolis.
* Lyman T. Meiks, Indianapolis.
* F. S. Crockett, Lafayette.
* W. H. Howard, Hammond.
* A. J. Sparks, Fort Wayne.
* W. L. Portteus, Franklin.
* A. P. Hauss, New Albany.
* J. E. Ferrell, Fortville, president-elect.
* Cleon A. Nafe, Indianapolis, chairman, Executive Committee.
* C. H. McCaskey, Indianapolis, member, Executive Committee.
* Mr. Albert Stump, Indianapolis, attorney, Indiana State Medical Association.
* Mr. Thomas A. Hendricks, executive secretary.
* Mr. Ray E. Smith, assistant executive secretary.

*(* Those so marked were present.)*

Dr. Kennedy thanked the members of the committee for the tremendous amount of work they had done, particularly the members of the subcommittees, who were assigned the task of making a thorough study of the three plans of insurance, that is:

(1) Plan for a medically-owned stock company to carry on the insurance plan of indemnity type;

(2) Plan for a contract with an organized private corporation to carry on the insurance plan of indemnity type;

(3) Plan for a service plan by a mutual organization providing for a set fee covering entire service.

He said that these three subcommittees were fact-finding committees; that they had conscientiously and thoroughly delved into the matter of finding the advantages and disadvantages of each plan; that following presentation of their reports these committees would be released from the plan on which they were reporting, and that the committee members could support any plan they chose. He then called upon the chairmen of the subcommittees to read their reports. These were presented as follows:

On Plan No. 1, by Dr. Crockett. (See page 409)
On Plan No. 2, by Dr. Manion. (See page 413)
On Plan No. 3, by Dr. Hauss. (See page 414)

Following discussion of these reports, the committee adjourned for lunch.

The Committee reconvened at 2:00 P.M.

Dr. Dodds made the motion that the discussion be limited to one hour. Motion seconded by Dr. Crockett, and carried. The chairman announced that the committee would vote at 3:00 o'clock.

Dr. Nie presented the following resolution:

WHEREAS, the House of Delegates of the Indiana State Medical Association, in the November, 1944, meeting, voted to approve a prepayment type of indemnity insurance; and

WHEREAS, the House of Delegates at the same meeting instructed the president of the State Association to appoint a committee on prepayment medical care to work out a plan to have the insurance carried by an Indemnity Company;

THEREFORE, this committee hereby recommends to the House of Delegates a plan whereby indemnity insurance may be carried by any old-line indemnity company.

After some discussion, Dr. Nie asked that his resolution be amended by eliminating the words "old line" and inserting "any insurance company approved by the Indiana State Medical Association."

Dr. Sparks moved the rejection of Dr. Nie's resolution.

Dr. Nie made the motion that his resolution be adopted. This motion was lost for want of a second.

Dr. Kennedy moved the adoption of the following resolution, the blank to be filled in by the adoption of a secondary resolution:

The Committee on Prepayment of Medical and Surgical Care recommends to the House of Delegates for adoption and effectuation the plan of medical care in which . . . (here insert type of plan approved).

This motion was seconded by Dr. Crockett, and passed.

Dr. Hauss made the motion "that this committee go on record endorsing and recommending a mutual medical service plan for Indiana, and that the words 'mutual medical service plan' be incorporated in this resolution."

This motion was seconded by Dr. Sparks, and passed on a standing vote—11 members for and 5 members against the motion.

Dr. Kennedy proposed the following resolution:

RESOLVED, by the House of Delegates of the Indiana State Medical Association, that the President be and hereby is, directed to form an agency under the suitable name, composed of eleven members, six of whom shall be members of the Association and one member from and representing each of the following: Industry, Labor, Hospitals, Agriculture, and Women. The term of office of members shall be three years with not less than three expiring each year. The first appointees shall have staggered terms.

The then President of the Association shall be ex-officio member for the current year.

The agency, when formed, shall have authority to inaugurate and carry on the plan of prepayment medical care adopted by the House of Delegates.

The name of the agency, nominations to membership therein, and its contracts shall be with the approval of the Council.

The agency shall in no manner obligate the Association to any financial responsibility, and, at all times in all agreements, the Association, through its Council, shall maintain general control of the adopted plan and the methods of its administration.

Dr. Kennedy moved the adoption of this resolution. Motion seconded by Dr. Howard. Motion lost on voice vote.

Dr. Sparks made the motion, "I move that this committee recommend that the Council be designated as the agency to set up the organization of the plan and the necessary method of operation, after it is approved by the House of Delegates." Motion seconded by Dr. Manion, and passed.

The suggestion was made that the minority group submit a report to the House of Delegates. Thereupon Dr. Portteus made the motion that "this committee cast a unanimous vote for this plan that was approved by the majority this afternoon. I move that we cast a unanimous vote which will give us a chance to show that we will support this thing." This motion was seconded by Dr. Manion, but was lost by one dissenting vote.

The meeting adjourned at 3:50 P.M.

THOMAS A. HENDRICKS,
Executive Secretary.

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## REPORT OF SUBCOMMITTEE No. 1
to the
## COMMITTEE ON PREPAYMENT OF MEDICAL AND SURGICAL CARE OF THE INDIANA STATE MEDICAL ASSOCIATION

### DOCTORS FORMING THEIR OWN COMPANY

The directive from our chairman to this subcommittee charges us with exploring the advantages and disadvantages involved in developing our own prepayment medical plan. I have read the summaries submitted by the other subcommittees, and wish to compliment and commend each of them for doing an excellent job. Subcommittee III reported on the advantages of the Service Type, as distinguished from the Indemnity Type Plan. There is very little difference in the practical working experience. Under the Indemnity Plan, successful operation demands doctors fees in harmony with the earning capacity of the patient. Service Plans provide fees based on this same principle. The difference is largely ideologic. The Indemnity Plan does not require advance compliance from the doctor, nor does it set a fee for the service rendered piecemeal or collectively as a finished service. The patient and the doctor remain free agents in every respect, as they now are. There is no question that, to the man of low income, the complete coverage of expense, both professional and hospital, is preferable. I think we can understand this, and I hope the tendency to overuse so inherent in the Service Plan, where another hospital service costs nothing additional, will be recognized as another reason why an Indemnity Plan that may require something extra, for another service, while not enough to defeat actual needs, will prevent whimsical or elective overuse. This question has become more or less academic since our House of Delegates approved the Indemnity Plan. I trust that this action will not be reconsidered.

Since the Indemnity Type Plan has been adopted as the official preference, Subcommittees I and II were charged with studying what amounts to this question of "Who should own the business?" When we boil all the arguments down, the decision to form our own insurance company or contract with a commercial company to carry on and underwrite the business means just that. Who is to own the business? On the one hand, the business is ours to develop and direct in the best interests of the public and the profession, or we lend our professional prestige and support to develop what becomes the business of a corporation foreign to the practice of medicine.

The real purpose that brings us here is to find the best way to give the greatest amount of protection from the catastrophic costs of illness to those in the so-called "low-income group."

If we will keep this primary objective in mind our discussion of the relative merits of doing the job ourselves or contracting with a casualty com-

pany to do it for us will hinge upon which method will do the job best. I am sure we all concede that it can be done either way.

The comparison of methods should show:

1. Which method through low-cost administration will return to the policyholder the greatest portion of the premium dollar.
2. Which method will assure the policyholder greater consideration in the matter of disputed claims.
3. By which method the high ethical standards and independence of the profession can be best preserved.
4. Which method will best enable us to hold the high confidence of the public we seek to serve.
5. Which is the better method to convince the public that this can best be done by voluntary means rather than through compulsory legislation.

There are certain differences in the conduct of a mutual company, such as we contemplate, as distinguished from the conduct of a commercial company, such as the report of Committee No. 2 contemplates. One such difference, which is usually not thought of, is the psychological one: "For whom is the company operated?" In a commercial company the business is run for the stockholder. It is organized and operated to render a service, but this must be done in such a way that a profit is earned. There is nothing wrong in earning a profit, and much good flows from it. Nevertheless, when decisions must be made where the element of profit is threatened, the need for profit becomes the determining factor. That explains the presence of so many exceptions or limitations in all commercial contracts. These are escape clauses. They are put in to protect the company. We might do the same in similar circumstances, but we must avoid this in our plan.

The demand for a plan permitting budgeting for catastrophic illness is based on the concept that the plan will give the greatest possible protection in the widest spread of possible need. The effort is to protect every situation that may happen to the policyholder within the limits of available money.

This means giving each beneficiary of the plan everything we have that will redound to his improved physical condition. Can this be done by a commercial company? A commercial company gives the policyholder only that amount it is compelled to give, after taking advantage of all exceptions.

Experience has shown that a mutual company, such as we recommend, operating on a very low administrative cost, can reach a point where eighty cents of the premium dollar can be used for the policyholder, compared to the much smaller portion of the premium dollar when administered by commercial methods. Is the employer and employee going to be satisfied with any plan that gives less protection than is given in other states? Our plan will be viewed by the American Federation of Labor and the C. I. O. in comparison with their experience elsewhere.

We have also kept in mind the factor of our control. We believe that you want to own and control this plan. There should never be any question about who owns it. To determine this question of control, let us first examine the factors involved if we contract with a commercial company. The one complete proposition received is that of G. H. Poulsen & Company, of Toledo, Ohio.

G. H. Poulsen & Company, in collaboration with the Academy of Medicine of Toledo and Lucas County, Ohio, in July, 1944, a little over a year ago, opened the Toledo Plan. This company, independently of the Toledo medical protection, writes also lines of industrial group insurance, such as Health, Accident, and Life. This Company presented a prospectus to your subcommittee.

The part the company would expect the membership of the Indiana State Medical Association to have in the enterprise is stated very clearly in the prospectus and at considerable length. The full statement need not be incorporated in this report.

G. H. Poulson & Company would require full cooperation of the Indiana State Medical Association, as follows:

1. We doctors must endorse the plan in writing, giving Poulsen & Company permission to use the endorsement in all their sales promotion literature.
2. We must give full cooperation in its organization and preparation of the plan.
3. We must give full cooperation in the operation of the plan.
4. We must apprise all the doctors of the State of Indiana of the pressing need for such a plan, so that the weight of their influence will be back of it.
5. Our responsibility shall not be a financial one, but only a moral one.
6. We must sample public opinion through our county organizations, so that current situations may be met as they arise.
7. We must keep the entire membership of the association informed as to the progress of the plan, so that they will feel that it is their plan and that it is to their best interests to advance its welfare in every way possible.
8. A full liaison man——
9. We must agree to help Poulsen & Co. secure newspaper releases; however, before such release is made, it shall first be approved by our committee and G. H. Poulsen & Co.
10. We must, where feasible and proper, promote the best interests of the plan through contacts with employers and heads of associations.

G. H. Poulsen & Co. agree that if for any reason they find it advisable to withdraw from this plan, they will give not less than three months' notice of such intent to the Indiana State Medical Association, unless governed otherwise by federal laws, state laws, or regulations.

It seems that G. H. Poulsen & Company has gone to great length to mention everything they can think of to meet objections, and have shown by their proposed agreement that they wish to protect

us in every way. I doubt if any other company would do as well.

While recognizing their sincerity and earnest desire to deal with us, certain questions not mentioned in their proposal should be brought up.

1. This company sells other lines of group insurance. Our endorsement of them for our particular policy would be hard to separate from our lack of endorsement of their other lines.

2. Poulsen & Company are agents of Metropolitan Casualty Insurance Co., of New York, which carries the risk. Would the Metropolitan be a party to this contract?

The advantages claimed by the proponents of employing an insurance company to handle the coverage are fourteen in number, and apply with equal force to any form of indemnity insurance we decide to adopt, with the exception of the first three, which deal with the financing and managing involved if we elect to organize our own company. We wish to discuss them.

1. "It avoids the need for raising funds from physicians and/or the Indiana State Medical Association."

By way of explanation of this point, the requirements for a company to be organized and owned by doctors in Indiana are the raising of $25,000 capital to be deposited with the Insurance Department of the State, and $25,000 prepaid insurance business. We do not know just what the response will be if we seek subscriptions from individual doctors for a total of $25,000.

In Ohio, just recently, $150,000 stock was subscribed by the doctors in two weeks, Dr. McCormick told me. Dr. Olsen told me that in Iowa each doctor was asked to subscribe $25.00. In Indiana, assuming that all the money required would have to be put up by the doctors, if all our three thousand members participated, it would amount to only $8.33 for each of us. The $25,000 prepaid premium, I am informed, can be obtained in six to eight weeks. During this time, the necessary legal work of organization could be set up. This means that we can get going with our own company as quickly as promised by the commercial company.

2. "It avoids financial responsibility in case of mismanagement or failure or actuarial shortcomings."

It may avoid financial responsibility, but we should point out that the "reasonable control" and "moral obligation" delegated by the private company to our association would visit just as great odium on the Indiana State Medical Association in case of failure of a commercial company. It could not be avoided because of the indorsement in writing, required of us.

In the proposal of G. H. Poulsen & Company there is no provision for termination of the contract, except through misconduct on the part of the company, or through their own election.

Recently, in conference with Mr. Poulsen, this was called to his attention, pointing out that after a period of time or term of years there should be an automatic end to the contract, at which time a new contract could be made or our own company could take over. After thinking this over several days, I received the following letter from him:

"August 29th, 1945

"Dr. F. S. Crockett,
Lafayette Life Building,
Lafayette, Indiana.

"Dear Dr. Crockett:

"I want to thank you for the time and trouble you took in conferring with me regarding a Medical Service Prepayment Plan for the State of Indiana. It was very kind of you to invite me to your club for lunch. I thoroughly enjoyed it, and I also appreciated your courteous reception of our ideas.

"I realize that your main objection to a private enterprise company handling a prepayment plan for doctors is that there apparently is no getting-off place for the doctors if at sometime in the future the doctors should desire to run their own company. There certainly is merit to your idea on this, and I can see no objection to having a clause whereby this could be accomplished. Such a clause should include provisions that first a proposal should go through the proper committees and then be passed by the House of Delegates. However, in order to insure the public's interest, there should be a similar request from employers or organizations who represent over 50 per cent of the people covered under such a plan. By this means, the majority would rule as to whether this business should be taken over by a doctor's company or by ours. This should be fair to both the doctors, the public, and the heads of industry; however, to make it fair to us, there would have to be a reasonable sales price, such as is used in the sale of an insurance company's assets, as well as a reasonable period of time before this could be brought up. This is, of course, only a rough outline of such an agreement, and I would be very pleased to get your additional ideas regarding it.

"I do feel that we can do a real job in putting this program over, and sincerely hope you will be in favor of giving us the opportunity.

"Again, I want to thank you for the very courteous reception you accorded me.

"Sincerely,
G. H. Poulsen,
*President.*"

As you can see from this letter, if we contract with a commercial company, the business will be their property. If at a later date we wish to take over, we would be expected, as they state, to pay the commercial company a reasonable sales price, such as is used in the sale of an insurance company's assets. Having contributed the principal element, that is our endorsement, that made the plan go, we would have no interest, no equity in it. I see no point in doing anything involving the standing and reputation of the profession if we are not to own as well as control it.

Your subcommittee has not been able to discover any preponderance of value or advantage in this commercial proposal. The reasonable control and supervision of the business of this company on the part of our state association would call for a thorough understandable knowledge of the very things needed in the conduct of our own company.

The part of the premium dollar available for the purpose of indemnity payments is that amount left after costs of doing business have been met.

A commercial company must either join with the Blue Cross organization, such as we propose and as I understand was done in Toledo, or get business by the more expensive personal solicitation.

Settlement of claims must be done by an adjuster, the usual commercial method, or through county committees of doctors. It is important, if the purpose of this plan is to succeed, that benefits should be settled on the broadest basis possible for the benefit of the policyholder, and not from the standpoint of protecting the stockholder. A commercial company must take taxes and profits out of the premium dollar. It is difficult to see how any commercial handling of this plan can mean as much to the beneficiaries or to the doctors who do the work and benefit by the size of the indemnity paid.

With our own company, the Board of Directors could have representation from those affected by the plan—that is, doctors, employers, employees, farm groups, and the public, a pooling of consumer interests with professional control, impossible with a commercial company.

There are many insurance companies now in Indiana writing indemnity health insurance on a commercial basis. Why then is it considered necessary for the medical profession to add another unless the indorsement of the medical profession must be there to create a certain confidence not present without it? If our indorsement makes this difference, then the element we give makes it our peculiar property and creates whatever value it contains which is not present in other policies.

*Advantages of our doing the job ourselves:*

We would own and control our own plan.

Financing our own plan would be through subscriptions of members of the profession or other citizens interested in promoting the plan as a public service. In Ohio the 150,000 stock was sold in two weeks to Ohio doctors.

The Blue Cross would prefer a companion plan created by the medical profession. We would sell our policy with the Blue Cross as a full coverage.

Incorporation of our own company would follow the line already approved by the State Insurance Department in the organization of Blue Cross. It will require very little time to incorporate. All the difficulties were solved in organizing the Blue Cross.

The time is short. Immediate readiness for business is assured through association with Blue Cross, whose sales force is waiting for our plan. They can get the 25,000 prepaid premiums in six to eight weeks. The promotional literature and policy forms are available for immediate use from other state plans.

Those who control the money and the experience will exert an ever-increasing influence on the conduct of the business.

If we indorse a Commercial Company Plan, the business will be conducted under their name. The master policy and individual policies will bear their names. It will be their business.

If we later want to organize our own company, we would find it difficult to make the change, as we would have to buy the business back from the Commercial Company.

Conducting this business would cost the commercial company considerably for four principal reasons:

1. They must protect their agents so that new business in their territory brings them income. 2. Settlement of claims requires the visit of an adjuster. 3. Taxes must be paid. 4. Something must be put aside for profit.

*With our own company:*

1. The cost of getting the business is shared with the Blue Cross—a much lower cost than if done by agents. 2. Medical Advisory Committees in each county would adjust claims, and do it with an understanding-doctor viewpoint. 3. There would be no taxes to pay. 4. There would be no profit accruing to the corporation. This saving on all four items would make possible indemnity payments higher than any commercial company could make.

With our own company, the Board of Directors could have representation from those affected by the plan, that is, doctors, employers, employees, farm groups, and the public, et cetera, a pooling of consumer interests impossible with a commercial company—yet under the control of the medical profession.

### ADVANTAGES

We would own and control our own plan.

Financing of our plan would be through subscriptions of members of the profession or other citizens interested in promoting the plan as a public service.

The Blue Cross would prefer a companion plan created by the medical profession. We would sell our policy only to those having Blue Cross.

Incorporation of our own company would follow the line already approved by the State Insurance Department in the organization of the Blue Cross.

The time is short. Immediate readiness for business is assured through association with Blue Cross whose sales force is waiting for our plan.

Those who control the money and the experience will exert an ever-increasing influence on the conduct of the business.

We are in favor of private enterprise—the private enterprise of the medical profession.

We are opposed to tax exemption. We do favor giving doctors more money to make taxpaying easier.

We are in favor of the profit system and want the profit to go to the doctors who do the work.

We favor indemnity payments covering all hospitalized sickness, medical and surgical. All obstetrics should be paid for whether in the hospital or home. An annual examination should be included.

If we indorse a Commercial Company Plan, the business will be conducted under their name. The master policy and individual policies will bear their name. It will be their business.

If we later want to organize our own company, we would find it difficult to make the change, especially if employer and employee were satisfied.

It costs the Commercial Company considerable for four principal reasons:

1. They must protect their agents so that new business in their territory brings them income.
2. Settlement of claims requires the visit of an adjuster.
3. Taxes must be paid.
4. Something must be put aside for profit.

With our own company:

1. The cost of getting the business is shared with the Blue Cross—a much lower cost than if done by agents.
2. Medical Advisory Committees in each county would adjust claims and do it with an understanding-doctor viewpoint.
3. There would be no taxes to pay.
4. There would be no profit accruing to the corporation.

This saving on all four items would make possible indemnity payments higher than any commercial company could make.

With our own company, the Board of Directors could have representation from those affected by the plan, that is, doctors, employers, employees, Farm Bureau, et cetera, a pooling of interests impossible with a commercial company, and yet under the control of the medical profession.

DISADVANTAGES: NONE

A. Jerome Sparks, M.D.
W. H. Howard, M.D.
Wemple Dodds, M.D.
F. S. Crockett, M.D., *Chairman.*

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## REPORT OF SUBCOMMITTEE No. 2

The subcommittee to study a plan for prepayment of medical and surgical care of the Indemnity Type, offered by a private insurance company operating under reasonable control of the Indiana State Medical Association, finds that such a plan presents the following advantages:

(1) It avoids the need for raising funds from physicians and/or the Indiana State Medical Association.

It is conceivable that we might need to raise funds several times. It is said that we should be in a position to lose half a million dollars in the first few years of operation.

(2) It avoids financial responsibility in case of mismanagement, failure, or actuarial shortcomings.

Can we be sure that we have, in our membership, men with the "know-how" to direct and control an insurance company?

(3) Physicians are not obliged to enter another field of endeavor.

We steadfastly resent encroachment upon the private practice of medicine; we therefore should not encroach upon the enterprise of our friends in the insurance profession. If this principle of encroachment is sound, then why not enter upon other fields of allied endeavor, such as surgical supplies and drugs?

(4) The operations are under the supervision of the Indiana State Insurance Commission.

It seems that an old-line insurance company is less likely to be subjected to special regulations by the state insurance commission than is a so-called "non-profit company."

(5) It preserves the physician-patient relationship.

In the eyes of the patient the physician is not also a representative of the insurance company.

(6) It allows the physician to set his own fees.

(7) It is consistent with our belief in the principle of private enterprise.

The care of the sick is our private enterprise, and the profit motive has a great deal to do with our doing a good job of it. This plan is private enterprise and subscribes to private initiative for profit. If it is all right for us to take the profit out of the insurance business, why could not the government take over and take the profit out of both the insurance business and the practice of medicine?

(8) It eliminates suspicion.

We need not face the accusation that we are coming in on both ends of the deal.

(9) It avoids possible political control.

We believe a private enterprise is less inviting to men of government than one that implies a semi-public nature by its non-profit slogan.

(10) It eliminates the possibility of political intrigue within the association.

This is big business.

(11) No outside organization can take over control as is possible with a company operated on a mutual basis.

In a mutual company, each policyholder is a stockholder; if a large number of them chose to attend a meeting and vote as a bloc, they could take over control of the company.

(12) It allows for broadening, as experience permits, to cover every form of medical practice—in hospital, home, or elsewhere.

(13) An experienced organization now in operation is available.

(14) It can be in full operation here almost immediately.

The subcommittee finds that such a plan presents the following disadvantages:

(1) It limits our ability to control the policies of the company.

Although we may control all policies that are consistent with good business principles.

(2) Theoretically, the premiums would be greater and/or the benefits less.

If there were two equally efficient companies operating, one non-profit and the other old-line, the non-profit one would return more of the premium dollar to the patient.

(3) In case of insoluble dissension the business would belong to the insurance company.

However, all records would be available to us.

(4) It does not enjoy the advantage of the non-profit slogan.

Which is a doubtful advantage.

JOSEPH L. ALLEN, M.D.,
WALTER L. PORTTEUS, M.D.,
MARLOW W. MANION, M.D., *Chairman.*

## REPORT OF SUBCOMMITTEE No. 3

Your subcommittee appointed to report on the Service Plan of prepaid medical care accepted the assignment with no misgivings as to the handicap of reporting on the merits of a plan that was condemned to die by the Reference Committee of our 1944 House of Delegates.

Our instructions from Dr. Kennedy were sort of "writ of habeas corpus ad deliberandum," which Mr. Stump will tell you means a writ to produce the prisoner in order that he may be tried in the proper jurisdiction wherein the criminal act was committed. We therefore say to this honorable court of inquiry, "Cepi corpus et paratum habeo," which you Latin scholars know means, "we have the body and we have it ready."

In identification of our client, the Service Plan, and as evidence of the character of this said defendant, we submit as Exhibit A the official report of the 1944 Permanent Study Committee on Health Insurance, as presented to the House of Delegates of the Indiana State Medical Association in session at Indianapolis, October 5, 1944, by Dr. W. H. Howard, chairman. The report was as follows:

### "REPORT OF PERMANENT STUDY COMMITTEE ON HEALTH INSURANCE

"Your committee was appointed by the House of Delegates at the 1943 annual session to recommend 'the most feasible' insurance plan for medical services.

"Over the past several years a tremendous amount of study and effort has been devoted in an attempt to develop methods of distribution of medical care and alleviation of the high costs of illnesses, particularly for those with small incomes, which are unpredictable as to amount and time of occurrence.

"Your committee has met numerous times and has investigated the development of plans and methods of the distribution of medical care in other states and countries, and has arrived at the conclusion that the best present solution is the adoption of a state-medical-association-sponsored plan for prepayment for medical service—that is, the adoption of the insurance principle to payment for medical service.

"In Indiana, due to deficiencies for this purpose in the non-profit corporation statutes and due to the lack of specialized legislation permitting the formation of a voluntary prepayment medical service plan, it will undoubtedly be necessary to organize under the insurance statutes of the state either a mutual or stock insurance company or association in order to carry out the recommended proposed program.

"Because the required capitalization or funds necessary to qualify for transaction of business are much more probable of attainment, your committee recommends that a mutual insurance company be organized with contributed funds of $25,000, and an additional $25,000 to be derived from advanced premiums, a total of $50,000, the amount necessary to meet the qualification requirements of the statutes.

"Contributions to the funds of the insurance company can be made on a so-called 'surplus contribution note,' repayable out of surplus earnings as, if, and when such funds are available.

"The plan proposed by your committee would provide:

(1) For all professional medical, surgical, and obstetrical services while the patient occupies a ward or semi-private hospital bed, including anesthesia, x-ray, laboratory, and electrocardiographic services.

(2) Emergency surgical services in connection with non-hospitalized injuries for the first twenty-four hours.

"These services will be subjected to the following limitations:

(1) Ten-month waiting period for obstetrical cases.

(2) No obstetrical benefits unless family is enrolled.

(3) X-Ray service limited to fifteen dollars in any one year.

(4) Twenty-one days of medical care in any one year.

"Your committee contemplated that members of the profession enter into agreements with the service to provide contract benefits at fees in accordance with necessary rules and regulations determined by a committee or committees to be appointed by the association for that purpose.

"It is further contemplated that physicians so agreeing will abide by fees established by those committees, except when an unmarried subscriber's annual income exceeds $2,000, or a married subscriber's total family annual income exceeds $2,500.

"The subscriber rates proposed for this coverage are approximately 95¢ per month for an individual contract, and $3.25 per month for the family contract.

"Necessary action to incorporate such a company should be referred to a committee of the state association to draw up incorporation papers—Articles and By-Laws, which should designate the desired number of directors, which is suggested at from eleven to twenty-five. By-Laws should outline the various operating committees to transact detailed business of the organization, such as: Executive Committee to conduct the affairs of the organization between meetings of the Board of Directors; Medical Committee to determine and resolve matters in relation to the practice of medicine, fees to be paid in connection with services rendered by participating physicians, et cetera. By-Laws should also designate the offices and duties of the offices of the corporation and qualifications of those to hold office, such as president, vice-president (one or more), secretary, treasurer, and so forth. By-Laws should further designate the method of employing the active manager of the organization and his qualifications.

"A preliminary draft of a proposed subscriber's agreement which sets forth the benefits offered, limitations, procedure for enrollment of subscribers, and rights and privileges under the contract has been prepared by the committee. The subscriber rates proposed will be available for any action committee.

"It will be noted that provisions of the Medical Plan Contract in regard to enrollment requirements, transfer privileges, et cetera, in connection with subscriber's rights and privileges, are insofar as practical identical with those set forth in the proposed contract of the Mutual Hospital Insurance, Inc., (Blue Cross Hospital Service of Indiana) plan, it being contemplated that upon the incorporation of the medical plan, arrangements will be made with the hospital insurance company for a joint enrollment and subscriber relations administration for the benefit of reduced operation costs and economies.

"Your committee believes the proposed plan meets in all respects the principles laid down by the A.M.A. in regard to sound medical service plans.

"Your committee recommends that a special reference com-

### A REAL TRIPLE THREAT!

The second contest took place on November 12, in a special court of the House of Delegates, and if it will not offend His Honor, Judge Kennedy, and the dignity of this honorable Court of Inquiry, we will briefly present it to you as the sports editor of our State Journal would have reported it, if we had a sports editor.

They kicked the ball around all morning without much ground being gained by either side, and in the afternoon, right in the midst of the third quarter, they decided to play the second quarter over. Neither the Indemnity Team or the Service Plan boys were able to advance on line plunges, and both sides were thrown back on attempted end runs and intercepted forward passes.

In the fourth quarter both sides began punting the ball out of bounds. Finally, when darkness came and neither side knew what they were doing, Umpire Oliphant handed the ball over to Referee Forster to hold until new teams could be coached to play the third and perhaps deciding game.

FINAL SCORE OF SECOND GAME

Indemnity—0 Service—0

FEATURES OF THE GAME

Kickoff by Brunk of Michigan. Signal calling by Captains Howard and Crockett. Punting by Sensenich and Nafe. Defensive play of Romberger, Kennedy, and Daniels. Interference of Mitchell, Weinstein, Nie, Brubaker, Rupel, and Atkins. Line plunges by Wadsworth, Black, VanReed, Sparks, Stocking, Davidson and Giordano. End runs by Jones, Elsten, Thompson, Casebeer, and Portteus. Return of punts by Catlett, Topping, and Hahn. Safety by Hauss and Romberger.

DIQUALIFIED: "Mutual" and "Non-Profit"

SUBSTITUTIONS: "Approved" for "Sponsor"

OFFICIALS

Umpire, Oliphant; Referee, Forster; Head Lineman, Stump and Hendricks; Timekeepers, Wagner, Murray, and Dingell.

THIRD GAME TODAY KENNEDY PARK
SEMI FINAL—INDIANA MEDICAL LEAGUE CHAMPIONSHIP

A Double Header

MUTUAL NON-PROFIT INDEMNITY BRAVES
vs.
MUTUAL NON-PROFIT SERVICE PLAN REDS
and
COMMERCIAL INDEMNITY ALL STARS
vs.
PREPAYED MEDICAL CARE DODGERS

Final Game to be played in the Stadium of the House of Delegates

PENNANT WINNER OF THE INDIANA MEDICAL LEAGUE
will meet
WAGNER AND MURRAY'S DINGLING SENATORS
in
THE WORLD SERIES OF 1945

A. P. HAUSS, M.D.

mittee of the House of Delegates be appointed to consider this report and other reports and resolutions having to do with pre-payment medical and hospital care plans and programs.

"The committee cannot express sufficient thanks and appreciation to Jay C. Ketchum, executive vice-president of the Michigan Medical Service, and president of the Medical Service Plans Council of North America, for the inestimable services rendered the committee in preparing this report and aiding in the study of prepayment plans."

## PERMANENT STUDY COMMITTEE ON HEALTH INSURANCE

W. H. Howard, M.D., *Chairman*

As Exhibit B, in further explanation of the meaning of the Service Plan, we refer you to the history, reports, and records of five years of actual operation of a similar service plan in the State of Michigan, and to the numerous articles and comments published in our own state journal pertaining to the Michigan Medical Service.

We find that the committee making that report was mandated by the House of Delegates at the 1943 annual session to study and recommend "the most feasible" insurance plan for medical service.

We find that the Committee met numerous times and has investigated the development of plans and methods of the distribution of medical care in other states and countries, and arrived at the conclusion that the best present solution would be a *Service Plan*, patterned after and based on the experience of the Michigan Medical Service.

We find that after a year's study and sincere deliberation a Service Plan was recommended to the House of Delegates.

We find that the report was then referred to a special reference committee, and that this reference committee, after one day's sincere deliberation (day-light saving time) rejected the Service Plan with a preamble of complimentary and consoling remarks, commending the Service Plan Committee for the excellence of its report, and stated, "We recognize that such service groups have worked very well in other states, but we feel that the majority of those who appeared before our committee favored an indemnity form of insurance for Indiana."

Then this reference committee having already acknowledged that the Service Plan had "worked very well in other states" may have had some uncertainty about the financial success of an indemnity plan, for they next insert in their report the following paragraph (we quote):

"Your committee is of the opinion that the financing of the plan adopted should be carried out without the use of funds at present in the treasury of the state association.

"Your committee, therefore, recommends and moves that the state association form and operate its own non-profit indemnity plan of health insurance."

Thus, the report of the Permanent Study Committee of Health Insurnace and the report of the Reference Committee were placed before the House of Delegates.

The House of Delegates, being a very deliberative body, then deliberately refused to render a decision and ruled that the case be retried within sixty days. (See box insert on page 415.)

And now that you have been given all the sport news, your subcommittee, appointed to investigate and report on the Service Plan of prepaid medical care, seriously and respectfully submits the following evidence:

Our findings considered unfavorable to the Service Plan are as follows:

(1) The Reference Committee of the 1944 regular session of the House of Delegates reported that the majority of those who appeared before the committee favored an indemnity form of insurance for Indiana, and not the Service Plan. The Reference Committee recommended that our state association form and operate its own Non-profit Indemnity Plan, not a Service Plan. (See The Journal, page 615, November, 1944.)

(2) In a mutual company the governing power rests in the hands of the subscribers. To offset this possible control, the Indiana Service Plan provides that the subscriber must surrender his proxy at the time of subscribing, in order that control of the organization remain with the medical profession. The effectiveness of this provision is destroyed when the subscribers appear in person. It may not be probable, but it is still legally possible for large organized farmer, labor, or other subscriber groups to appear in person and take away from the medical profession the control of the organization. (See pages 107, 108 and 109 of the Minutes of the Tri-State Meeting—held October 29, 1944, at Cincinnati—of the A.M.A. Council on Medical Service and Public Relations.)

(3) The Service Plan as proposed for Indiana, and as now operated in Michigan, is based on what some term "contract practice of medicine." (See page 104, A.M.A. Council Meeting at Cincinnati.)

(4) The set fees for medical care as provided for in the Service Plan arbitrarily evaluates the services of the doctor and places an arbitrary limit on his fee.

(5) It will be difficult to set up a physicians' fee schedule that is actuarially sound and also acceptable and satisfactory to all physicians concerned in the various localities over the state. (See schedules now in effect in Michigan, California, and elsewhere.)

(6) Revenue of the Service Plan and for payment of the doctor is mainly based on employment and payroll deductions. Success of the plan depends largely on prosperity.

(7) There is a maximum set on your return, but there is no minimum value set on your fee. (See pages 104, 105, Minutes of A.M.A. Council at Cincinnati.)

(8) The Service Plan would be of limited bene-

fit to the public or physicians in counties or districts without hospital facilities, as hospitalization is required. (See committee report, THE JOURNAL, page 501, October, 1944.)

(9) The provision to limit subscribers to the Service Plan from certain low income groups is said to be impractical and is being disregarded by the Michigan Medical Service. (See J. Ketchum's statement, THE JOURNAL, page 618, November, 1944.)

(10) In Michigan it was decided to retain the "full service" provision for employees within the established income limits, but also to permit higher income employees to enroll with the understanding that the participating doctor retains the right to make a charge to the subscriber in addition to the fee he received from the Service. (See THE JOURNAL, page 618, November, 1944.) Issues involved: First, How many participating doctors would dare render an additional bill? Second, Would the average subscriber willingly pay this extra charge, or would he simply write on the physicians statement "S.B.," meaning, of course, "submitted bill?"

(11) Medical Service limited to participating doctors is not entirely a "free choice of physician" plan.

(12) Limitation of "twenty-one days of medical care in any one year" is not favorable to general practitioners.

(13) The plan chiefly favors the "specialities" (see George Daniels' question, "Are there any other general practitioners here?" THE JOURNAL, page 743, December, 1944.)

(14) The Service Plan's fee schedule, when adopted and printed, may establish a precedent for all medical service charges throughout the state.

(15) The Service Plan may encourage unnecessary hospitalization.

(16) The Service Plan is considered by many to violate medical tradition and physician-patient relationship, by injecting a third party into the picture, who pays the insurance of the patient direct to the physician.

(17) Doctors are not actuaries. Success of the Service Plan would depend on efficient promotional and business management. We will have to find another Ketchum to run the thing for us.

And this is off the record—It is said that J. Ketchum is not obtainable, so it has been suggested that U. Ketchum, I. Signum, and W. E. Treatum would be a good combination.

This being about all the unfavorable points that we could find, we now submit the following points in favor of the Service Plan.

(1) The House of Delegates of the American Medical Association has approved in principle, Service Plans as well as Indemnity Plans in the field of prepaid sickness insurance. (See *Medical Economics*, page 84, May, 1945.)

(2) Medical Service Plans officially approved and adopted by ethical organized medicine in various states now serve more subscribers and physicians than any other plan officially adopted or managed by organized medicine. (See Sensenich statement, THE JOURNAL, page 732, December, 1944.)

(3) The workability of the Service Plan has been proved by others.

(4) The Service Plan in Michigan, California, and elsewhere now appears financially sound.

(5) Points 2, 3, and 4 make the Service Plan more attractive to both subscribers and physicians, because adventurers into new and unfamiliar fields prefer to take the traveled road, the beaten path, or at least a blazed trail.

(6) The Service Plan as a mutual and non-profit organization is a selling point of great advertising value.

(7) The Service Plan covers most of the catastropic illnesses of the average family.

(8) It provides for full payment of medical cost of these illnesses in hospitals.

(9) The subscriber having his catastropic illnesses prepaid becomes more economically sound, and has more money to pay his physician for office calls and home service.

(10) Payment of the physician is guaranteed for services rendered in the hospital, for surgical, obstetrical, or medical care, and also for emergency surgical services for non-hospitalized injuries for the first twenty-four hours.

(11) The Medical Service Plan works well with the Blue Cross and other established hospital service plans.

(12) The Service Plan's enrollment requirements, transfer privileges, subscribers rights, and provision for family coverage are nearly identical to those set forth in the subscribers contract of the Indiana Blue Cross Hospital Plan, and the two services can be sold as one package through a joint sales administration, thereby reducing operative costs.

(13) Combined Medical and Hospital service is more desirable to the average subscriber, and is easier sold to the larger industrial groups of employees and management because it can be purchased in one package.

(14) The Indiana State Medical Association, if it so desired, could organize, own, operate, and control its own mutual non-profit hospital service plan to augment its medical service plan. This might offset any attempt of the Blue Cross to form a corporation for the practice of medicine, and employ physicians on a contract basis. It has been attempted in other states. (See Romberger's statement, THE JOURNAL, page 733, December, 1944.)

(15) It would not be compulsory for all physicians to become participants in the Medical Service Plan.

(16) Stipulated fees for medical services in the established Medical Service Plans, such as Michigan Medical Service, are equal to, or more than, the average amount received for like services from the low-income groups in most communities.

(17) The employed administrators and executives of the Medical Service Plan and the sub-

scribing members or patients have nothing to do with the setting of fees paid for professional medical services. These fees are determined by committees of doctors themselves.

(18) Participating physicians of the Medical Service Plan are not required to abide by the Service Plan fees when the unmarried subscriber's annual income exceeds $2,000, or a married subscriber's total family annual income exceeds $2,500. In these instances the Service Plan guarantees the payment of the established fee direct to the physician, as an indemnity, and any additional charge may be billed to the subscriber.

(19) The cost to the patient in mutual Nonprofit Service Plans is said to be less than the cost for like service in Indemnity Plans.

(20) Complete prepayment of medical services for hospitalized catastrophic illnesses is pleasing and attractive to subscribers.

(21) Service Plan provides for the patients free choice of participating physicians.

(22) Certain professional medical services are now included in the Blue Cross Hospital Plan in Indiana. These are x-ray diagnosis, anesthesia, pathology, and laboratory service, electrocardiography, and basal metabolism. The Medical Service Plan will take these strictly professional procedures out of the Hospital Plan and place them in the Medical Plan, where they belong.

(23) The Medical Service Plan need not be financed by the treasury of the Indiana State Medical Association, or become a financial obligation of the state association.

(24) The required initial capital for organization of a mutual company is much less than is required for a stock company.

(25) The Service Plan would be entirely under the control and direction of the physicians of Indiana, as long as the proxy provision holds good.

(26) The Service Plan provides prepayment for all professional, surgical, and obstetrical services, and for twenty-one days of medical care per year, when the patient occupies a ward or semi-private hospital bed — including anesthesia, laboratory, basal metabolism, electrocardiographic services, and a limited amount of x-ray service.

(27) The Service Plan thus presents a method of distribution of adequate medical care and alienation of some of the high costs of illnesses which are unpredictable as to amount and time of occurrence, and it particularly comes to the aid of those with small incomes.

(28) There are many who believe that "adequate medical care" and "free choice of physician" are the cardinal principles of American medical tradition and physician-patient relationship, and that the method of payment of the physician is secondary.

In conclusion, your subcommittee wishes to state that it found a basis for all the foregoing statements, for and against the Service Plan, but recognizes that some of the statements are debatable.

Respectfully submitted,
C. Phillip Fox, M.D.,
Claude Dollens, M.D.,
Augustus P. Hauss, M.D., *Chairman.*

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## RADIO CALENDAR

"YOUR HEALTH IN WARTIME"

Hear these broadcasts each week:

Indiana State Medical Association — "Ladies, Your Health!"—Monday, 2:00 P.M., WFBM, Indianapolis

Vigo County Medical Society — Thursday, 12:15 P.M., WBOW, Terre Haute.

St. Joseph County Medical Society — Friday, 1:45 P.M., WSBT, South Bend.

(Watch for announcement of new time for "Doctor Goodhealth" program.)

## INDIANA STATE BOARD OF HEALTH

### DIVISION OF COMMUNICABLE DISEASE CONTROL

**Monthly Report—August, 1945**

| *Diseases* | *Aug. 1945* | *July 1945* | *June 1945* | *Aug. 1944* | *Aug. 1943* |
|---|---|---|---|---|---|
| Chickenpox | 20 | 55 | 162 | 11 | 15 |
| Measles | 22 | 39 | 145 | 16 | 60 |
| Scarlet Fever | 52 | 77 | 219 | 55 | 34 |
| Typhoid Fever | 5 | 6 | 10 | 13 | 10 |
| Whooping Cough | 135 | 127 | 103 | 62 | 193 |
| Diphtheria | 17 | 14 | 24 | 18 | 28 |
| Influenza | 17 | 6 | 23 | 6 | 14 |
| Pneumonia | 1 | 0 | 6 | 3 | 7 |
| Mumps | 37 | 58 | 186 | 9 | 23 |
| Poliomyelitis | 43 | 5 | 7 | 108 | 12 |
| Cerebrospinal Meningitis | 5 | 12 | 7 | 10 | 19 |
| Nonepidemic Meningitis | 1 | 0 | 1 | 0 | 1 |
| Undulant Fever | 5 | 7 | 4 | 6 | 8 |
| Rocky Mountain Spotted Fever | 8 | 0 | 6 | 2 | 0 |
| Tetanus | 1 | 0 | 1 | 0 | 0 |
| Encephalitis Lethargic | 4 | 1 | 0 | 2 | 0 |
| Infectious Jaundice | 7 | 2 | 5 | 0 | 0 |
| Rubella | 4 | 4 | 6 | 0 | 14 |
| Malaria — Acquired Outside United States | 5 | 3 | 3 | 10 | 0 |
| Septic Sore Throat | 8 | 1 | 1 | 0 | 0 |
| Bacillary Dysentery | 1 | 0 | 0 | 0 | 0 |
| Ringworm | 6 | 0 | 0 | 0 | 0 |
| Impetigo | 3 | 4 | 5 | 1 | 3 |
| Erysipelas | 1 | 1 | 2 | 2 | 0 |
| Tuberculosis, Pulmonary | 214 | 185 | 285 | 365 | 106 |
| Tuberculosis, Other Forms | 6 | 11 | 12 | 11 | 33 |

*THE JOURNAL*
OF THE
INDIANA STATE MEDICAL ASSOCIATION
DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA
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OCTOBER, 1945

# Editorials

## Annual Convention

of the

Indiana State Medical Association

French Lick Springs

November 6, 7, and 8, 1945

Have you made your reservation?

## INDUSTRIAL HEALTH

This is our fourth Industrial Health Number of THE JOURNAL, and consequently reflects a continued interest in this field by Indiana Medicine. The interest has been a wholesome, progressive one, and should reap benefits as time goes on. It has been progressive in that we practically have reversed ourselves as to fundamental concept of what constituted the field of Industrial Medicine.

It wasn't so long ago that the average physisian doing industrial work was appropriately called the "industrial surgeon," for his chief job was traumatic surgery. Gradually the concept changed until today it is felt that industrial surgery is not the chief responsibility of the plant medical officer, but that the *prevention* of industrial accidents and diseases is the order of the day. In fact, it has been said in support of this change that every industrial accident or disease that occurs is a direct black mark against the Medical Department. This concept is very perceptible in Indiana, for our Annual Industrial Health Conferences emphasized this point by supplying data on how to prevent the occurrence of the major industrial diseases. Thus lives have been saved, morbidity has been reduced to a low point, earnings of the worker have increased, and production has reached unprecedented heights—a true monument to industrial medical practices in this state.

Imbued with this basic concept of an industrial medical practice, our state society has developed methods of training physicians for industry, has sponsored postgraduate courses, developed and promoted progressive legislation, and begun to develop a far-reaching educational program for the physicians doing part-time industrial work.

The bulk of industrial medicine in Indiana is done by the part-time medical man, and therefore he becomes the most important man in this field. Thus, the county medical society becomes the foundation upon which our entire success or failure in this field rests. The state and federal groups may plan and make pronouncements, but it is the individual physician, cooperating with his conferees in his own community, on which we must depend to carry out these plans.

To place the responsibility in the local community the Committee on Industrial Health of our state association has asked that each county or district medical society have at least one program devoted to industrial medicine each year. Speakers can be supplied if necessary, and any other help is readily available. Out of this request have come some outstanding developments, such as the in-plant type of medical meeting sponsored by the Grant County Medical Society and the clinic-type developed by Lake County.

All in all, we realize that industrial medicine offers us a challenge, and thus far we have more than met it. It's nice to see Indiana Medicine well ahead in this new field of medical endeavor.

## HOOSIER MEDICINE AND THE WAR

We are, indeed, proud of the record of Hoosier Medicine during the late war, a record that is not surpassed by any other state. About one-third of the association membership enlisted in the Army or Navy Medical Corps, while every other able-bodied physician in the state, regardless of age, carried on at home. We again take our hats off to these groups.

But there is another group which, without fanfare of any sort, has carried on a vital, most-important work, referring to the local members

of the Procurement and Assignment Service. Each county had a committee whose duty it was to catalogue every physician in that county; they were listed as available or as unavailable for military service—medical, of course. There were many occasions when this listing was done under rather severe handicaps; in a few instances there was a bit of politics, logrolling, or what have you. In practically every instance, however, these committees went along quietly and unperturbed, and completed the survey.

There were also instances where members of these committees were censured by civilians—occasionally by members of doctors' families—because they were adamant. When they said that Doctor Blank was not indispensable to his community, that was that—he was *not* indispensable, and, sooner or later, he was inducted into the Medical Corps. The great majority of younger physicians, men under forty-five years of age, did not, however, await the verdict of the Procurement and Assignment Service; they just joined up.

So it is that we say that these "procurement" members, throughout the state are, for the most part, the "unsung" participants in the war. And it is to them that this editorial is directed; we want them to know that we have not overlooked the services they have rendered.

And there is another man, an Indiana physician, who deserves a full twenty-one-gun salute; a man who has been on the job every day from the beginning of the war until the last gun had been fired—he still is on the job and is likely to be for some time to come. We refer, of course, to Colonel Charles R. Bird, of Indianapolis, who is state chairman of the Procurement and Assignment Service.

Most Indiana doctors are wholly unfamiliar with the work this man has done during the past four years, nor do they know of the long hours he has spent in organizing and conducting this enormous project. It is to his faculty for organization and to his fairness to all concerned that a great part of the success of the undertaking is due. We happen to be quite familiar with the work Colonel Bird has done, and is continuing to do.

And, with the official close of the war his duties seem to have multiplied. Rehabilitation problems, it seems, continue to occupy his time and attention; men returning from service, as well as those about to return, come to him for suggestions as to where to locate and, in some instances, wish advice concerning financial matters; some being financially unable to set up an office.

Not all the financial problems come from physicians, however, as is evidenced by the plaint that comes from a large Indiana hospital, stating that they have to pay their house physician six hundred dollars per month in order to retain an indispensable feature of the organization. In peacetime, as is well known, these medical officials are to be had for a much smaller competence, usually recruited from the intern staff. Other hospitals call in person or by phone, stating that their resident physician is of military age and fitness—"Won't you use your good offices to help us retain such a necessary man?"

Some of our Medical Corps personnel has been out of real practice for varying periods of time and need to be re-oriented, many of them needing postgraduate work.

It is true that the "G. I. Bill of Rights" provides means whereby such men can get government loans at a low rate of interest, but this does not appeal to some. So they contact Colonel Bird, hoping that he has the answer to the problem. Many tales of such hardships are poured into the ears of the chairman, one story being of particular interest just now, when every effort is being made to protect the physician who left his practice and who now wants to return. It seems that a young physician had been deferred from military duty because he was indispensable; later, he left that position and went to another town buying a practice therein, and rather effectually shutting out a doctor who had left that community for service.

Colonel Bird long ago suggested that the state association should create a rotating fund, this to be loaned to men returning from the service when such funds were needed. Another suggestion has been made that the State of Indiana, through the newly-created Veterans Affairs Division, do something helpful in this matter.

So continues this job, day after day, with new problems arising every little while, and, as we have said, Colonel Bird is presumed to have the solution for each one of them. Hence, do we briefly record the part that Indiana Medicine played in the Procurement and Assignment Service by hundreds of our physicians, under the direction of Colonel Bird. Nor should we overlook the fact that we rendered still another service in "loaning" Tommy Hendricks to this bureau; for some time he spent approximately half of his time in Washington, serving as official consultant to the bureau.

It is fitting, we believe, that this tribute be paid to the men who volunteered their services for such an important work, and the Herculean task so well accomplished by Colonel Bird.

# OUR DAY

It seems that everyone is having his or her day, so we finally decided to have one, too. As early as last March we decided that our annual trek to the Canadian wilds was out of the book, having talked with railroad officials about train service. The gas situation being what it was precluded any notion of traveling by auto, our favorite for this particular trip. We even had told the camp manager that we would not be there in 1945. Then came V-J-Day, and a day later gas rationing was out, so hurried preparations were made, and we left on August thirtieth.

Cutting diagonally across the State of Wisconsin we noted many changes, here and there, in the two years since we had made the trip by car. The first thing we missed was the pea hullers, which in July are to be seen every few miles. The peas, of course, had long since been processed.

Nature has been good to Wisconsin, as well as other sections this year. Where on other trips we had noted brown pastures in many sections, this year the grass was lush, as evidenced by the appearance of the grazing herds. One very noticeable thing was the marked increase in traffic. With gas again available to every car owner, it seemed that they were all on the highways. Seldom have we seen such a huge volume of traffic at this season of the year.

Another very noticeable thing was the fact that too many drivers apparently have forgotten how to drive with safety. Passing cars on hills and curves was very frequently observed, and many drivers failed to signal when they wished to make a turn—probably all due to the fact that most cars had not been driven very much in the last two years.

Throughout Minnesota we noted many new houses and barns, and much newly-cleared land; apparently the farmers in that country are sharing in the general prosperity of husbandmen throughout the country. Dairying is markedly on the increase in Minnesota, and where in other years we saw the usual "family flock" of chickens, this year we noted farm after farm where hundreds of chickens were seen, and the chicken houses were of the most modern type. What used to be "pin money" for the farmer's wife now seems to be a small industry.

We crossed the border at International Falls, arriving in Fort Frances, a very busy and very clean little city. Custom men on both sides of the border advised us that the traffic between the two countries had had an amazing step-up since the end of gas rationing. This was quite apparent, Fort Frances' streets being jammed with cars from every state in the Union.

Economically, Fort Frances is very prosperous, although her shops and stores still are short many of the items that tourists have been wont to buy in former years. Men's clothing is now seen displayed in the stores, whereas a year ago that store got a few suits each four months. One dealer whom we have known for a good many years stated that he would have men's dress shirts in about a week—a year ago a white shirt was not to be had in the town.

They have one meatless day each week—Friday; butter is rather scarce, and sugar *very* scarce. Meat is again being rationed—last year it was not. The meat, however, is in good supply and of very high quality. Cheese, unrationed, is to be had in about the usual supply, although not so well aged as in former years. Canadian Stilton, as well as English Stilton, still is off the market.

In contrast to last year, western Ontario shows very little war atmosphere. Where a year ago there was much marching of the drum corps, the British flag being displayed everywhere, this year the martial spirit is not so much in evidence. Canadian army and navy men, returned from service, are to be seen on the street in large numbers. The army uniforms worn at this season are of heavy wool—look mighty hot, but the wearers seem not to notice it.

The Labor Party's victory in England seems not to disturb the average Canadian very much; they have little to say about it. They are apparently satisfied with having Mackenzie King as their Prime Minister for another term.

Getting aboard the *Shir-Dot* after the usual delay, and heading up Rainy River, Rainy Lake, Seine Bay, and the Seine River, we came to Grassy Creek, where our camp is located. Arriving rather late in the evening, we failed to notice whether the fish eagle nest was occupied—that meant a trip down the river, since this has come to be one of the points of interest on this trip.

Reaching the camp site we were a little puzzled. In former years a sizeable party of Indians had come down from the village, some twenty-eight miles up the river, for the summer season, camping on a point of land adjacent to our camp. Here they lived in tents, wigwams, and whatnot; this year they had built cabins for themselves. We have not been over to inspect the camp as yet, but from a general observation we would say that the usual number of children are there.

The Indian guides appear to be in better health than usual. Johnny Willie, who a year ago was on his way to a tuberculosis hospital, in Fort William, is again on the job and looking well. We were a bit perturbed to hear from his daughter that Charlie Friday, one of our favorite guides—and professional liars—was ill, but the next morning he came along with a "Hello, Doctor." We were glad to see Charlie was back. We gave him one of our older reels, and a few minutes later he was out in his canoe, trying it out.

"Harry," one of the camp owners, told us of a new boat he was having made by one of the Indians. He gave the order about two months ago, and the Indian immediately "took to the woods," returning with a cedar log in tow. With a saw, a handmade drawknife, a small plane, and a hammer as work

tools, he has made a beautiful boat which will be officially "launched" tonight. We may go over and break a bottle of beer as a part of the program. Some of the canoes, Indian made, are works of art, and the moccasins remain as handsome as in former years.

We have now spent two days in camp, and no fishing as yet; THE JOURNAL material must be prepared before we get to that chore—orders from headquarters. Mac and Buck are out today, and we plan to start the angling program on the morrow. Fishing, in general, has been the best in years. During one week in July eleven muskies were brought into camp, the largest scaling an even forty pounds. These eleven muskies created quite a furor in fishing camps in the area, one owner taking a week-end trip to the Mudge Camps to see what it was all about.

Deer seem to be plentiful, but the partridge crop probably will be short, due to the rainy summer. Ducks are appearing in large numbers, most of them having nested hereabouts; the ones from farther north are not coming down as yet. Hunters from "The States" are expected in larger numbers this season than in former years. One outfitting company at Fort Frances told us that inquiries had been received in greater numbers than at any time in his memory. The moose country is farther north, although they are no strangers to this area. (Two "oldsters" chronic fishermen for years, just this moment came in—midafternoon, with the "limit" of walleyes and smallmouths, as pretty a string of fish as we ever have seen—caught with plugs and spoon.)

So begins "our day" in the Canadian woods; fish or no fish, we will have enjoyed every minute of our stay, what with perfect September weather, a new cabin with the best of beds, plenty of good food—in fact, too much; we are wont to say—most gracious hosts, good guides—everything that make for a worth-while outing.

## THE UNDERTAKERS COMPLAIN

From several sections of the state complaints have been filed at headquarters by undertakers in the matter of difficulty in obtaining signatures to death certificates by doctors. They declare that even when the doctor is found in his office, they are required to await their turn in seeing him, which often means delay.

Doctors, of course, are busy men these days, what with about one-third of them in service, but the undertaker, too, has his side of the story—he can not remain away from his office too long.

We have asked Drs. Leroy Burney, State Health Commissioner of the Indiana State Board of Health, and Thurman B. Rice, Professor of Public Health, Indiana University School of Medicine, each of whom are entirely familiar with all laws and rules pertaining to such matters, to present an authoritative statement, which is presented in this issue of THE JOURNAL. We trust that every member will take time to read this informative article. Several suggestions are made therein that, if followed, will materially expedite matters.

Attention is also called to a growing evil, that of signing blank certificates or permitting the mortician to attach the name of the physician. Not only is this a violation of the law, but a custom that obviously might lead to trouble.

As suggested by the writers, it takes but a moment to sign a certificate, and arrangements can and should be made whereby the paper is taken directly to the physician by the office attendant. And, in case of absence, arrangements should be made beforehand with a confrere who can take care of the matter.

We are, indeed, proud of the fact that Indiana long has been a pioneer in matters concerning health records of all sorts, and hope that every effort will be made to meet the full compliance of our health laws. Doctor Rice, when he was health commissioner for the state, made such matters a fetish—he wanted everything in this connection done exactly right. Doctor Burney is the same sort of chap, wants to create no hardships on any member of the profession, yet wants things in "apple-pie order." He is exceptionally well trained in health work and merits the complete and friendly cooperation of the entire profession. Let's see that he gets it!

## REACTION ON OKINAWA

On V-J Day we heard many comments such as, "I wonder what the boys in the South Pacific are doing tonight; I wonder just what their reactions are." A letter from a chap whom we have known throughout his twenty-five years gives a partial answer to the query, and we quote most liberally therefrom. This lad had a naval service of a bit more than three years at the time of the surrender, being attached to a communication unit on "The Rock," as he terms the island. He is a radio operator, land base, and when the news reached the island he was on duty in "The Shack," as the boys term their particular radio room.

It was a matter of four or five days before he could write home, due to the fact that the station was very busy, as one could surmise. Then, too, as he puts it, "I couldn't have written a letter, because my mind was so muddled and confused that my perspective was shot. I was hoping and praying that the news would be good, and yet I had a terrible gnawing sensation in my stomach that kept telling me to quit counting on peace terms. It just seemed too wonderful to be true. I was on duty at the 'shack', around 9:15 P.M., when all hell broke loose on this island. Tracer bullets could be seen everywhere in the sky, and red, green, and white flares were seen all over the place. I immediately thought of a paratroop invasion; my first

reaction was one of fear, and a dull pain hit my stomach. Then someone called that the war was over; we caught that over our radio. I still wasn't convinced that there wasn't a hell of a raid on, and still kept near a trench I had spotted in my frenzy. Gradually, it began to dawn on my numbed brain that Japan had really suggested peace, after all. Further reports kept filtering in about the peace offer, and my hopes looked brighter."

Then he discusses the atomic bomb, to which, together with the entry of Russia into the war with Japan, he attributes a great share in the Nip proposal. Commenting on the fact that some United States civilians already were criticizing the use of this bomb, he said, "I know a bomb of such power sounds horrible, but it has saved the lives of countless thousands of American men who would have died on the plains and beaches of Honshu. And as for anyone who says we never should have used that weapon on the Japs, I say, bring them out here to live under our conditions. Nine out of ten of them would change their mind, while the tenth will be too damn stubborn to admit it."

Speaking of the celebration which soon began after the news had been verified, he said, "I was standing outside with one eye on the fireworks, the other on a foxhole. There was an ensign standing with me at the moment the whole thing dawned on me. Then the spirit moved me, and I began pounding Vic on the back, exclaiming, 'Vic, it's all over!' The next four days were the worst days I ever spent; I really sweated it out. I was dejected and quite positive that the war would not end then. The morning when the official announcement came it was raining like all hell, but things never looked so bright to me. I must admit that I was feeling pretty happy about the whole thing. I am actually glad I have had a chance to come out here and take part in the operation, and see things a civilian cannot visualize; it has been a great experience and a great lesson. I just hope that the world will remember this war—the next one would leave no chance for memories."

There we have the mental picture as seen by a young chap who was in the midst of things. We see the varied mental processes that took place in his brain on this historic occasion; he speaks entirely without reserve, not omitting a few of the milder "cuss words," which we never heard him use at home. Yet, these words are so expressive that we condone them.

This letter is but one of thousands that were written by American forces to the folks back home. It is no different than most of the others, but it happens to be the only such letter we personally read, and, as we have said, we have known Tommy a good many years—all his life in fact—which makes such a communication of much personal value. He is just another one of the armed forces, one unit in the greatest army and navy of our country—just another one of the millions of boys who did their part and is now happy that the end of the war has come.

# Editorial Notes

Upon the recommendation of its president, the Oklahoma State Medical Association has embarked upon an educational program that would seem to cover practically the whole field. This will be carried on by the utilization of the press, radio, motion pictures, and a speakers' bureau. The Governor and the heads of educational institutions, along with other notables, have agreed to participate in this program. In sending us this information, president Tisdal says, "from the above you will see that Oklahoma has an energetic, practical program of education," to which we most heartily agree.

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The *Evansville Press* directs the attention of its readers to the fact that there are still many Indiana physicians in the armed forces, and that the best thing to do, in case of an emergency, is to take the patient directly to the hospital. That is good advice since most city hospitals have a staff of physicians, many of them having house physicians and interns, some of whom are available within the institution.

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The United Nations Relief and Rehabilitation Administration is doing a most valuable work in Greece, China, and in the Balkan States, in the way of health measures. In Greece the campaign is at present centered on a mosquito-control campaign. In Bulgaria the distribution of penicillin is a major program. Few of us know or realize just how desperately health measures are needed in these war-ridden countries, and it is comforting to know that some responsible agency is in charge.

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Saturday night, September first, will go down in our book as a memorable occasion. Sitting before the fireplace in a camp in western Ontario, with our two vacation companions and our host, we listened to the surrender program as broadcast from the *U. S. S. Missouri*, in Tokyo Harbor. The voice of General MacArthur came in clearly, as did the others, and the entire proceedings were so well broadcast that we could easily imagine ourselves as spectators. In the solitude of the Canadian woods country, with not a sound other than the voices coming over the radio, one had plenty of opportunity for reflection. As the program went on, and as each signer of the surrender papers were announced, we were thrilled, more so than when we first heard of Japan's eagerness to give up the fight. General MacArthur's opening statement, though brief, convinced us that the real peace terms will be much to our liking. An hour later we were snuggled under our two blankets, with a sense of peace and security such as we had not experienced in some four years.

A newspaper clipping from a down-state paper speaks of the shortage of doctors in that county, and of the great advantage their local hospital has been during these trying times. It seems that one of the two doctors available had to go to a neighboring city for an operation, and the other was literally swamped with work. However, by sending as many as possible to the hospital he was able to care for all of them. Three babies were delivered there, so closely together as to have made it impossible to attend these three mothers had they been at their homes in various parts of the county.

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The 1945 "March of Dimes" topped last year's totals by more than fifty per cent, reaching a total of $16,589,874.00, so the National Foundation for Infantile Paralysis announced in a recent bulletin. This would indicate that the American people are fully aware of the ravages of this disease and mean to support any movement for its curtailment. The incidence of this disease in 1945 is reported as being unusually high, although not reaching the peak of 1944, when there were 19,272 reported cases in this country. Indiana is not listed among the states showing an increase during the current year.

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Sir Alexander Fleming, discoverer of the therapeutic value of penicillin, stated in a recent address that equally dramatic microbe-killers will be found. His prediction was that "we are only at the beginning of this great study." Like many other scientists, he has found, for instance, that in the soil of our gardens there are microbes, vigorous ones at that, that prey on other microbes, and our scientists are taking advantage of every opportunity to study these things. In making these comments Doctor Fleming made the observation that there is little likelihood of one getting too much penicillin, a statement that will do much to relieve those who have been wondering just how far they might go in its administration.

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During the Seventh War Loan campaign the newspapers, magazines, and radio contributed more than forty-two million dollars of free advertising space. The War Finance Division of the United States Treasury has expressed thanks to all concerned, meaning those who contributed to this vast total. At the same time we are advised that the *Victory War Loan* will call for additional space and efforts along this line. A lot of people have the notion that now that the war is over there will be no further need for such loans. Just a little thought will show this to be a very false conclusion. One item, for example: we have literally millions of men overseas, whose transportation bill in bringing them back home will run into the billions of dollars. These men will have to be "paid off," which also requires a lot of money. No, those who have done such a magnificent job in times past, in digging down into the bank roll, cannot let down in this regard. *Buy bonds and hold them!*

The United Nations Relief and Rehabilitation Administration, in an official bulletin recently issued, states that bubonic plague is spreading rapidly through certain section of China. This has spread inland from the coast provinces, the spread being attributed to the fact that transportation of rice to these inland areas has been carried out in the most primitive manner during the war, in order to avoid Japan-held areas.

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Ticks, those pesky little fellows that cause so much annoyance—at times worse than that—to vacationists, were numerous this past summer. Our host at a Canadian fishing camp stated that they were more numerous this year than usual. We again direct your attention to the fact that these little mites are commonly the source of the distribution of many diseases, particularly Rocky-Mountain spotted fever. Our host told of a moose that was shot near his camp that literally was covered with these ticks, to the degree that it was very much emaciated from loss of blood.

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The mosquito, long known as the distributor of malaria, yellow fever, and other diseases, now is charged with two new indictments, that of being a distributor of sleeping sickness and filariasis, as is pointed out in an article in the August 18 issue of *The Journal of the American Medical Association.*

Hammon, Reeves, and Brookman, all of San Francisco, and Benner of Yakima, Washington, report the results of their studies of annual epidemics of encephalitis in the Yakima Valley, while Captain Saphir reported on his studies of filariasis. The writer points out that the latter may be expected to appear in certain groups of soldiers returning from endemic areas.

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The Chippewa Indians of western Ontario have little or no meat problem. Ben Johnson, a guide at the Mudge Camp, told us how they prepare venison for winter use. The latter part of September he gets himself a deer, and along in October, after the freeze, he procures six of these animals. They are drawn and washed, then hung outdoors in trees, well off the ground so that varmints cannot get them. When his family—wife and five children—want fresh meat, Ben cuts off a portion, takes it into his home and lets it thaw for about five hours before cooking. Their fish is taken in the late fall, is thoroughly dried, then pounded into a powder and put away for future use. Ben does a bit of trapping, and his muskrats, for example, offer good, fresh meat, the "hams" being used. Certain other game which is being trapped offers a change in diet for his little family. The Chippewas, living on their own reservation of thousands of acres, are permitted to kill game and catch fish at any season of the year, which helps out considerably in these times.

The Indiana press again has taken up the fight against socialized medicine, prompted, we presume, by the new Wagner-Murray and the Pepper bills now before Congress. The *Bristol Banner* says, among other things, "When the government goes into business, that is socialism; so when the Federal Government establishes a system of insurance to which everyone must contribute; when it regulates the provisions of medical service through Washington headquarters; when it regulates fees that the doctors are to receive when they participate in this system; when it regulates those who are to be consultants and when consultants are to be consulted, that definitely is socialized medicine. The doctors who are dissatisfied with the system can quit and turn their ability to some other channel, but the people, once they are saddled with compulsory medical practices, are the losers, and they will definitely have to pay for socialized medicine, even though they prefer a private doctor."

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The Anderson municipal sewage disposal plant has been given a "clean bill" by state health officials who recently made an inspection of the plant and observed its operation. They are said to have been impressed by a new method of handling sludge, long a problem in some plants. Time was, and not so far back, when the easiest method of sewage disposal was to dump it, as is, in some stream, trusting that the natural aeration would take care of it. Later it was found that fish in these streams were dying by the hundreds of thousands, and a clamor arose from those who had been wont to do a bit of angling in the streams that once were noted for their fish population.

Some health officials became interested, and after a long legislative battle, covering many, many years, Indiana came up with a sewage disposal bill that is a model. It will be many years before this problem is completely "licked," but we are well on the way.

The Missouri General Assembly has enacted a law, which has been duly signed by the Governor and will become effective thirty days after adjournment of the legislature, having to do with the general use of the term "doctor." Our first impression on reading the act is that it contains little or no ambiguity. The reader gets a definite idea as to what was in the mind of the authors. Briefly, it makes it obligatory for all holders of licences to practice, and for healin' in that state, to indicate his field of practice by suitable abbreviations showing the degree he holds, this to be carried on letter heads, cards, billheads, and with any use of his name in connection with his professional work. Thus, a Doctor of Medicine must have his name appear as Dr. John Doe, or John Doe, M.D.

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Just about the time officials stop the sale and use of one of the various contraptions which are advertised as sure-fire diagnostic agents or cures, along comes another to try the patience of said officials. Heil Crum, of Indianapolis, made a box with a light in it, some wiring and whatnot, and did a thriving business until the authorities effectually put him out of business. Later, another, much more elaborate machine appeared and the Better Business Bureau had much to do with the exposure of this outfit. Then still another has appeared, called the "Spectra Chrome," sold by a New Jersey concern, the price being ninety dollars. From a newspaper picture of this machine we would say that it looks like an adorned rural mailbox. Federal officials interested themselves in the matter and confiscated one that had been sold to an Indianapolis resident. The guy who is said to have invented the machine has a very ornate name, according to this newspaper story—Dinshah Pestangi Franji Ghadiala. The case was tried before a federal jury, some six weeks being required for the hearing, which jury found that the machine was misbranded, under the terms of the federal Foods, Drugs and Cosmetics Act, and the outfit was turned over to the United States Marshal.

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## ANNUAL SESSION OF AMERICAN MEDICAL ASSOCIATION

### December 3, 4, 5, and 6, 1945

The Annual Session of the House of Delegates of the American Medical Association will be held in Chicago, Illinois, from Monday, December 3, to Thursday, December 6, 1945.

# President's Page

## MEDICINE IN INDUSTRY

Many are the tales of valor, of pure coincidental heroism, to come out of this war. Some of the stories have been celebrated in newsprint all over the world. A great deal will never be told because those who could do the telling are not here to speak. Within the ranks of the legion of workers and fighting men and women are those who by sheer strength of character have earned the plaudits of a freedom-loving people. To them personal freedom becomes a great telling force; theirs is a chapter as yet unequalled in modern history. Among them are the medics, the nurses, and the workers in warplants—little people who have helped make the more spectacular success possible. Without them the greater deeds of valor are never possible. Halls of fame may not be made small and common by using them to perpetuate the memory of victories. But who will say that they have not rendered as great a wealth of service as has been represented by any combat group.

In dedicating a special number of our JOURNAL to the topic of Industrial Health, recognition is again given to the important role which this phase of medical practice plays in our lives. The demands of wartime production placed a responsibility upon the shoulders of industrial surgeons, nurses, safety men, and the workers themselves which has no parallel in medical practice. The transition from peacetime production to the tremendous production for war, speeding up of operations, long hours of work, curtailment of relaxation, and a dozen other factors was met with such determination of purpose and general cooperation that safety records, based on man-hours of work, have been shattered month after month. Credit the workers themselves with a splendid spirit of effort; credit the safety man with superb ingenuity and alertness; and do not neglect to credit the industrial medical department with a devotion to duty and the fulfillment of a task so essential to keeping the worker in good health and on the job.

In spite of such victories, however, the return to peacetime production presents manifold additional problems. The question of returning the disabled veteran to work; the numerous programs for rehabilitation; health problems affecting industrial workers resulting from new products, new operations, and new hazards; the placement plans for the mentally ill and physically handicapped—these, and many more, build a mountain of endeavor which will occupy the attention of the medical man in industry for a long time to come.

It has been a long step from the primitive industrial first-aid station to the present-day concept of a medical department in industry. The path of progress has has been steep and the obstacles many. Industry has been reluctant, over the years, in subscribing to the necessity for an adequate medical service. The medical profession, too, has been sluggish in recognizing the highly-specialized character of industrial practice and in affording it the rank it deserves.

We may feel, however, that there can be no question concerning the value of the industrial medical department in the war effort, not only to the worker in industry, but to industry itself, to the maintenance of the production schedule, and to the reflected glory of the medical profession. Perhaps this should be glory enough.

N. K. Foster

*"In-plant" Industrial Meeting of Grant County Medical Society held at Owens-Illinois Glass Company.*

# DYNAMIC INDUSTRIAL MEDICAL PROGRAM SPONSORED BY THE GRANT COUNTY MEDICAL SOCIETY

LOUIS W. SPOLYAR, M.D.

Director, Division of Industrial Hygiene
Indiana State Board of Health

INDIANAPOLIS

The Committee on Industrial Health, of the Indiana State Medical Association, as part of its planned long-term program, has continually stressed the importance of acquainting the physicians of Indiana with current problems in industrial medicine. Numerous techniques were devised to accomplish this purpose.

Heretofore the Committee on Industrial Health sponsored an intensive two-day postgraduate course, held annually in Indianapolis, in co-operation with the Indiana University School of Medicine, and the Indiana State Board of Health. In addition to this, special issues of THE JOURNAL of the Indiana State Medical Association were devoted to industrial medicine. As a matter of fact, Indiana medical men developed both of these techniques to a point far surpassing the accomplishments of any similar group in the country. Just when things were coming along nicely and results could be seen, the ban on travel by O.D.T. completely curtailed this type of activity.

To continue the educational phase of the committee's program and still keep within the restrictions of the O.D.T. seemed to be an impossibility until Dr. E. S. Jones, chairman of the committee, suggested the answer: if the meeting cannot be held in a central area, reasoned Doctor Jones, then it should be *decentralized*, and each county or district medical society should have one of its monthly meetings devoted to industrial medicine. This was tried by five groups to date, and each reported a successful meeting.

When the Grant County Medical Society began thinking in terms of having its industrial meeting, Dr. Russell Lavengood, of Marion, thought that the only way to have an industrial meeting is to have it in a plant—in an industrial environment. Thus was born the in-plant medical society program on industrial medicine for Indiana. Place of birth was Gas City, and parents were the Grant County Medical Society and Owens-Illinois Glass Company.

Alec Turner, manager of the Owens-Illinois Glass Company, Gas City, invited the Grant County Medical Society to have the industrial meeting of the Society in the Owens-Illinois plant. Following the dinner the physicians toured the plant and actually saw all operations and control measures used. After

*Physicians touring the plant, inspecting operations and control measures.*

the tour an informal discussion on industrial health problems was held. In a round-table fashion practically all phases of industrial health was covered. The physicians asked the management questions, the management asked the physicians questions, and each in turn peppered questions to the author on legislation and occupational diseases and their control. It was a live, dynamic meeting, profitable to all.

A glance at the photographs appearing in this article will testify that the physicians were intensely interested in this on-the-spot, industrial-environment-type of program. It was instructive to physicians, for these workers are their private patients. One physician remarked, "Until tonight I had no clear-cut idea what my patients were talking about when they told me that they had a certain job to do, or that they were exposed to this or that material. Now I think I know." He does! In the future these physicians, through their first-hand knowledge of actual working conditions, will be in an excellent position to evaluate and appraise their patients' occupational complaints.

The Grant County Medical Association plan certainly deserves a great deal of consideration by medical societies and industries in that and other localities. Through such an intimate co-operation a mutual understanding of each other's problems will develop. This in turn will lead to better medical care, lessened absenteeism, and increased production.

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# CERTIFICATION OF PHYSICIANS AND SURGEONS IN INDUSTRY

EDWARD C. HOLMBLAD, M.D.,

Managing Director, American Association of Industrial Physicians and Surgeons

CHICAGO, ILLINOIS

In 1933, the House of Delegates of the American Medical Association established the approval of American Boards in the various specialties. Requirements for such boards to obtain approval were defined in June, 1934, and the Advisory Board of Medical Specialties was set up, consisting of representatives from:

Association of American Medical Colleges.
American Hospital Association.
Federation of State Medical Boards of the United States.
National Board of Medical Examiners.
American Board of Ophthalmology.
American Board of Otolaryngology.
American Board of Obstetrics and Gynecology
American Board of Dermatology and Syphilology.
American Board of Pediatrics.
American Board of Psychiatry and Neurology.
American Board of Radiology.
American Board of Orthopedic Surgery.
American Board of Urology.
American Board of Internal Medicine.
American Board of Pathology.
American Board of Surgery.
American Board of Anesthesiology.
American Board of Plastic Surgery.
American Board of Neurological Surgery.

Fifteen American Boards have been approved and are functioning as follows: Ophthalmology, 1933 (1917); Otolaryngology, 1933 (1924); Obstetrics and Gynecology, 1933 (1930); Dermatology and Syphilology, 1933 (1932); Radiology, 1933 (1932); Pediatrics, 1933; Psychiatry and Neurology, 1934; Orthopedics, 1934; Urology, 1934; Internal Medicine, 1936; Pathology, 1936; Surgery, 1937; Anesthesiology, 1937; Plastic Surgery, 1937; and Neurological Surgery, 1940. Several of these boards were set up by the re-naming and continuation of certification of specialists' examinations as conducted by the specialty societies, as indicated by the dates in parentheses. Thus, the American Board of Opthalmic Examinations had certified physicians by special examinations in that specialty since 1917.

The certification of physicians who have met required qualifications in the specialty of surgery was pioneered most excellently by the American College of Surgeons, since 1913, and undoubtedly was the stimulating example that promoted similar certification in the other specialties.

The history of the development of the specialty of Industrial Medicine and Surgery is quite similar to the development of other specialties. Physicians became interested in this particular field, Bernardino Ramazzini (1700) usually being recognized as the father of Industrial Medicine. Although some very excellent work was done in the 1890's by such pioneers as Dr. Andrew M. Harvey, retired medical director of the Crane Company, and others, most of the development started between 1910 and 1920. Such men as Drs. A. M. Harvey, Harry E. Mock, Charles G. Farnum, J. C. Stubbs, W. E. Post, Thomas R. Crowder of Chicago, and S. M. McCurdy of Cleveland saw the valuable opportunity of the exchange of ideas, discussions, and conferences about their special problems, and organized the American Association of Industrial Physicians and Surgeons in 1915. This organization has had special committees to consider the certification of physicians and surgeons in industry since 1937. In 1941, two committees were appointed to act jointly in studying this problem. The committee from the American Medical Association consisted of Drs. Robert T. Legge, William A. Sawyer, Leverett D.

Bristol, and Carl M. Peterson, and the committee from the American Association of Industrial Physicians and Surgeons were Drs. Frederick W. Slobe, Volney S. Cheney, Edward C. Holmblad, and C. O. Sappington.

The first meeting with the Committee on Standards and Examination of the Advisory Board for Medical Specialties was held in February, 1943. The carefully-worked-out organization plan for a Board of Physicians and Surgeons in Industry was presented and subsequently rejected on the following grounds:

1. The standards of the proposed Founders' Group were not clearly defined in proportion to qualifications established by other boards.

2. Adequate facilities for graduate training were lacking.

3. There was a question as to the existence of industrial medicine as a specialty.

The first objection has been easily met by restriction of the Founders' Group to less than one hundred men in this specialty with national reputations and authoritative standing. This could even be reduced to fifty should the Advisory Board for the Medical Specialties so desire.

The second objection appears to be the most valid, and efforts to set up adequate undergraduate and postgraduate training in the specialty are making excellent progress. Several university medical schools are pioneering or have already established departments, institutes, and even professorships of Industrial Medicine. The graduate training program will establish, most probably, a three-year training, including: first year, basic science; second year, hospital residency in traumatic and orthopedic surgery, and special training in such divisions as x-ray study of chest conditions, industrial dermatology and allergy, and occupational diseases and medico-legal studies. The third year will consist of some practical experience in an industrial hygiene laboratory, and mostly active, practical industrial medicine and surgery practice in an approved medical department in an industry of adequate size and scope to give a competent training for this fellowship. It is planned that these fellowships be set up on sustaining honorariums of $1,800 to $2,400 per year.

The third objection seems to be the least valid for the following reasons:

1. There is a regular section of the A.M.A. devoted to Industrial Medicine.

2. There is a listing of the literature of this specialty in the *Quarterly Cumulative Index*.

3. The *American Medical Directory* for many years has listed physicians specializing in Industrial Medicine by the abbreviation "Ind." after their names.

4. *Journal of Industrial Hygiene and Toxicology, Industrial Medicine* and other publications cover this specialty field.

5. The contemplated publication of a new periodical, under A.M.A. sponsorship, lends recognition to this field as a specialty.

6. For many years there have been societies and organizations of industrial physicians and surgeons too numerous to mention here.

7. Questionnaires to physicians in military service list Industrial Medicine as one of the specialties for postgraduate study.

8. The greatest argument that Industrial Medicine is a specialty is the fact that the American Medical Association has deemed it so important that it appointed a Council on Industrial Health, whose work in the development of this specialty has been outstanding in its scope and merit. Continuation of this very fine work can only serve to develop the specialty to the magnitude and recognition it has long deserved.

9. The work of the American College of Surgeons, through its Committee on Traumatic Surgery and Industrial Medicine, as well as its recognition and approval of Industrial Medical Departments meeting certain standards, has aided the recognition of this specialty.

10. Such organizations as the American Public Health Association, National Safety Council, Health League of Canada, and others have sections on Industrial Medicine.

11. World War II has recognized the importance of Industrial Medicine and Surgery as a specialty in many ways in war plants.

One of the primary objectives of obtaining certification of Physicians and Surgeons in Industry on an American-Board level is to interest the best medical talent from our medical schools to take up this specialty as a life career. It is a fascinating specialty full of adequate challenge for the development of the best that medicine has to offer. Who would deny that the workers in industry deserve the best-trained, best-qualified, and most competent physicians and surgeons that can be had?

Thus, progress is being made towards certification of Physicians and Surgeons in Industry, even though at times it may appear somewhat slow. May we feel that this slow progress proves the development of strength, refinement of quality, value, educational opportunities, self-realization, and better service to the workers in industry by the eventual approval of the "American Board of Physicians and Surgeons in Industry."

28 East Jackson Boulevard
Chicago, Illinois

# CONCERNING THE SIGNING OF DEATH CERTIFICATES

LEROY E. BURNEY, M.D.

State Health Commissioner, Indiana State Board of Health

THURMAN B. RICE, M.D.

Professor of Public Health, Indiana University School of Medicine

INDIANAPOLIS

Among the many progressive bills passed by the legislature of 1945 was one having to do with the matter of vital statistics. This was a bill uniform in character with those of some thirty-five or forty other states, and is essentially the same as the law passed in 1899 except that the present law is more accurate and specific in its requirements.

Indiana holds a proud place among the states from the standpoint of death registration, and is a member of the group of states known as the "Original Death Registration Area," by virtue of the fact that it was admitted to that select group in 1900. The states belonging at that time are the six states of New England, New York, New Jersey, Michigan, and Indiana. Previous to 1899 the law requiring death certificates was carelessly enforced, and the records were kept in the office of the local health officer. Since 1900 the original certificates have been sent to the State Board of Health, at Indianapolis, for tabulation, filing, and preservation. These records constitute an extremely valuable asset of the state. They have served an invaluable function in telling the medical and health profession what the important causes of death in the state have been, all to the end that effective remedial action might be taken.

The profession and the lay public need to know, in the most accurate way possible, exactly what diseases are taking the lives of our people, at what age they are dying, what parts of the state are most unhealthful, and how the deaths are divided as to race and sex. It is from such data that medical progress stems and health programs are planned intelligently. Life insurance companies and governmental agencies need information of this sort. This data must be as accurate as it is possible to make it, and it should be uniform with similar figures from our neighboring states. How can we get the best possible vital statistics and at the same time comply with the legal requirements?

Let us review the points in the 1945 vital statistics law which are apropos in the matter under discussion—the obtaining of accurate death certificates. When a patient dies it is expected that the undertaker will procure and fill out that portion of the certificate which pertains to the personal history of the individual—his name, age, marital status, sex, address, et cetera. He is then expected *to take the certificate to the office of the physician last in charge of the case and have him complete the certificate, giving the cause and the contributing causes of death, and thereafter affix his signature.* After this is done the certificate is taken to the health officer having jurisdiction, who copies the data in his book of records, and then once a month sends the original death certificates to the State Board of Health for statistical study and filing. He also *makes out a burial permit, which is given to the undertaker.* This permit should be filed with the office of the cemetery. If there is no such office the undertaker will do well to hold the permit in his permanent files.

Recently a difficulty has arisen and loose methods have been allowed to creep into practice. Doctors have been very busy, and undertakers have been short on time, gasoline, and tires. They have frequently called the physician on the case by phone, and he has *told* them the cause of death, and they have then *signed the physician's name* to this important original document. There are several serious faults in this practice, as can easily be seen.

In the first place, it is specifically against the law, which says that the physician must sign the death certificate, and that he must fill in the causes of death. Secondly, it can be inaccurate because the name of the disease might easily be misunderstood by the undertaker, who is a layman. Thirdly, a technical name might easily be misspelled or might be replaced by some name less embarrassing to the family. Fourthly, it is bad practice to delegate the signing of one's name to another person. Fifthly, we physicians are very much afraid that our work in the future may come to be done by someone else. We are properly jealous of our prerogatives and resent intrusion from the outside. This matter of signing death certificates is very specifically *our* responsibility, as set by law, custom, and common sense. If we turn this over to someone else, we may expect such persons to attempt to take over other responsibilities and privileges of ours.

We appreciate the fact that it takes time to get this record properly made out. Everything that is important takes time. We believe that the physician should cooperate in every way with the undertaker in getting this certificate promptly filled out. The family will, of course, want to be bothered as little as possible at the time, and may well expect the physician to do whatever is necessary so that the funeral arrangements can be made. The family has the right to expect the full cooperation of those who have been retained professionally. It would seem that an arrangement might be made whereby the undertaker could give the

partially-filled certificate to the office girl of the physician, who then could take it into his private office for immediate completion and signing by the physician. The undertakers complain that they sometimes have to wait for hours in the doctor's office (though we strongly suspect that it is rarely as long as that).

In some communities the health officer has gone away on vacation, or is out of town, and it is said that there was no way to get his signature on the burial permit. Most physicians, when they leave the community, make some sort of an arrangement for a colleague to take care of their calls. It would seem to us that it would be very easy for the health officer to ask this colleague to make out the burial permit when the death certificate has been properly filed with him in the absence of the health officer himself. This surely is not too much to expect of a professional man who has accepted the responsibilities of the practitioner of medicine and health officer. In some communities the health officer keeps a supply of death certificates and burial permits signed in advance, and the undertaker then fills in the details, as may be convenient. This is clearly a violation of the law, and a very dangerous and careless practice. Now that travel restrictions have been discontinued, there is no logical reason for such mishandling of an important legal responsibility. In case a body in need of a coronor's study would be buried without the expert opinion of the physician, an embarrassing problem might arise. We recommend urgently that the medical profession handle these matters in such a way as will bring credit rather than criticism upon our members.

We summarize the important points here as follows:

1. It is the duty of the undertaker to make out the death certificate—except such as has to do with diagnosis and the signature of the physician. He should secure the signature of the physician, should take the signed certificate to the health officer, and there get a burial permit before completing the burial arrangements.
2. The physician should *himself* write the cause of death, and the contributing causes, and then should personally sign his own name. This is the specific direction of the law.
3. The health officer should make it convenient—by deputy or another person if necessary—for the undertaker to get the burial permit promptly, and he should be very conscientious in sending the certificates to the State Board of Health once each month.
4. The cemetery should file the burial permits. If the cemetery does not do so, the undertaker should, for his own protection, keep such files for all bodies which he has buried.
5. The family of the deceased person has the right to expect the physician, the undertaker, and the health officer to cooperate in this matter so as to save embarrassment, waste of time, or unpleasant incidents. We strongly suggest that the physician cooperate in every way possible to help the undertaker complete the death certificate so it can be filed and preserved.

## RELEASE OF MEDICAL OFFICERS FROM THE ARMED FORCES

TO: The Editor of THE JOURNAL.

FROM: C. R. Bird, M.D., Chairman, Procurement and Assignment Service for Indiana.

The following is copy of a telegram received September 15 from the Procurement and Assignment Office, Washington, D. C.:

"ARMY MEDICAL CORPS OFFICERS WILL BE CONSIDERED SURPLUS AND SEPARATED FROM THE SERVICE IF THEY HAVE EIGHTY POINTS OR ARE FORTY-EIGHT YEARS OF AGE OR OVER, (EXCEPT FOR LESS THAN TWO HUNDRED SCARCE MEDICAL SPECIALISTS) IF THEY ENTERED ON ACTIVE DUTY PRIOR TO PEARL HARBOR. SCARCE SPECIALISTS WILL BE RELEASED IF THEY ENTERED ON ACTIVE DUTY PRIOR TO JANUARY 1, 1941. THIS MEANS THAT THE SURGEON GENERAL WILL RELEASE BY JANUARY 1 THIRTEEN THOUSAND PHYSICIANS, AND AN ADDITIONAL SEVENTEEN THOUSAND BY JUNE, 1946. FURTHER DETAILS WILL FOLLOW SHORTLY. WMPD."

On September twenty-eight we received the following telegram from our Washington Office in regard to the release of Medical Corps officers in the Navy:

"MEDICAL CORPS OFFICERS IN NAVY WILL BE ELIGIBLE FOR RELEASE TO INACTIVE STATUS IF THEY HAVE SIXTY POINTS ACCRUED AS FOLLOWS: ONE-HALF POINT FOR EACH MONTH ACTIVE DUTY SINCE SEPTEMBER 1, 1939; ONE-FOURTH POINT FOR EACH MONTH ACTIVE DUTY OUTSIDE UNITED STATES SINCE SEPTEMBER 1 1939; ONE-HALF POINT FOR EACH YEAR OF AGE COMPUTED TO NEAREST BIRTHDAY; TEN POINTS FOR ONE OR MORE DEPENDENTS. IN ADDITION NAVY WILL CONSIDER FOR RELEASE TO INACTIVE STATUS THOSE OFFICERS WHO HAVE BEEN AWARDED ANY ONE OF THE FOLLOWING SINCE SEPTEMBER 1, 1939: MEDAL OF HONOR, NAVY CROSS, ARMY DISTINGUISHED FLYING CROSS. THERE WILL BE SPECIAL DISPENSATION FOR RELEASE TO INACTIVE STATUS FOR THOSE WHO ARE PERMANENTLY LIMITED BY MEDICAL SURVEY TO SHORE DUTY AS A RESULT OF SERVICE-INCURRED DISABILITIES. WMPD."

In 1942, the Indiana Procurement and Assignment Service laid down the basis of deferment. In consonance with that policy, in order to be fair, the basis of recommendation for release from active duty is as follows, which of necessity cannot be rigid to the point of mathematical exactness:

1. Length of Service.
2. Fifty-year Age Group — Forty-year Age Group.
3. Overseas Combat Duty.
4. Overseas Rear Area Duty.
5. Civilian Coverage Needs.

It is not consistent with the spirit of fairness, for example, to process a medical officer for release who may be one of a group of ten, twenty, or thirty medical officers in his age group with more or less the same length of service and entitled to equal consideration.

# INDIANA PHYSICIANS RELEASED FROM SERVICE

| Name | City | County |
|---|---|---|
| Atcheson, Bellfield | Gary | Lake |
| Albertson, Frank P. | Indianapolis | Marion |
| Ball, Robert S. | Lebanon | Boone |
| Balch, James F. | Indianapolis | Marion |
| Ballenger, William E. | Richmond | Wayne |
| Baltes, Joseph H. | Fort Wayne | Allen |
| Beard, Paul H. | Indianapolis | Marion |
| Bendler, Carl H. | Gary | Lake |
| Boren, Paul | Poseyville | Posey |
| Bowers, Gah Theodore | Fort Wayne | Allen |
| Brodie, Donald Wallace | Indianapolis | Marion |
| Brookie, Roger William | Flora | Carroll |
| Butterfield, Robert M. | Muncie | Delaware |
| Carey, Charles K. | Rushville | Rush |
| Carroll, John Clayson | Decatur | Adams |
| Challman, William B. | Mt. Vernon | Posey |
| Clancy, James F. | Hammond | Lake |
| Coble, Frank H. | Richmond | Wayne |
| Coleman, Henry G. | Odon | Daviess |
| Combs, John H. | Evansville | Vanderburgh |
| Comer, Charles W. | Mooresville | Morgan |
| Cortese, Thomas A. | Indianapolis | Marion |
| Craig, Paul E. | Medaryville | Pulaski |
| DeWees, Dwight L. | Indianapolis | Marion |
| Dycus, Walter A. | Evansville | Vanderburgh |
| Eckhart, William Vincent | Marion | Grant |
| Eisaman, Cecil L. | Indianapolis | Marion |
| Engle, Russell B. | Farmland | Randolph |
| Fisher, John E. | Clarksburg | Decatur |
| Flanigan, Meredith B. | Indianapolis | Marion |
| Fox, Maurice H. | Bicknell | Knox |
| Foy, H. W. | Fort Wayne | Allen |
| Garland, Edgar A. | Evansville | Vanderburgh |
| Geider, Roy A. | Indianapolis | Marion |
| Geiger, Dillon Donald | Bloomington | Monroe |
| Gilbert, Ivan | Terre Haute | Vigo |
| Gingerich, Charles M. | Liberty Center | Wells |
| Glackman, John C., Sr. | Rockport | Spencer |
| Glaser, Robert E. | Brookville | Franklin |
| Goldstone, Adolph | Gary | Lake |
| Gray, Leon | Martinsville | Morgan |
| Haffner, Herman G. | Fort Wayne | Allen |
| Hepburn, Charles K. | Indianapolis | Marion |
| Hicks, James Maurice | Warsaw | Kosciusko |
| Hildebrand, Eugene, Jr. | Muncie | Delaware |
| Holladay, Lloyd J. | Lafayette | Tippecanoe |
| Houser, Wayne Woodruff | Monon | White |
| Husted, Robert George | Hammond | Lake |
| Ikin, Ray George | Lafayette | Tippecanoe |
| Inlow, H. H. | Shelbyville | Shelby |
| Jones, Wm. Wendell | Frankfort | Clinton |
| Kemp, W. A. | Connersville | Fayette |
| Klahr, Elsworth | South Bend | St. Joe |
| Kleindorfer, Roscoe | Evansville | Vanderburgh |
| LaSalle, Robert M. | Wabash | Wabash |
| Levi, Leon | Indianapolis | Marion |
| Loomis, Norman S. | Indianapolis | Marion |
| Loop, Frederick A. | Lafayette | Tippecanoe |
| Lyons, Robert E. | Bloomington | Monroe |
| May, George A. | Madison | Jefferson |
| McElroy, James | New Castle | Henry |
| McCoy, Roy R. | Fort Wayne | Allen |
| Mendenhall, Clarence D. | Indianapolis | Marion |
| Miller, David | Indianapolis | Marion |
| Miller, Milton J. | Evansville | Vanderburgh |
| Nance, William K. | Vincennes | Knox |
| Nisenbaum, Harold | Evansville | Vanderburgh |
| Norris, E. B. | Middlebury | Elkhart |
| O'Rourke, Carroll | Fort Wayne | Allen |
| Panares, Solomon V. | Hammond | Lake |
| Pennell, John | Kokomo | Howard |
| Pierson, Robert H. | Spencer | Owen |
| Quigley, Joseph Bernard | Indianapolis | Marion |
| Rendel, Harold E. | Mexico | Miami |
| Ritchey, John A. | Marion | Grant |
| Ritz, Albert S. | Evansville | Vanderburgh |
| Ragsdale, H. C. | Bedford | Lawrence |
| Rogers, Otto Floyd, Jr. | Bloomington | Monroe |
| Rothrock, Philip W. | Indianapolis | Marion |
| Salon, Harry W. | Fort Wayne | Allen |
| Schiller, Herbert A. | South Bend | St. Joseph |
| Schlemmer, George H. | Warsaw | Kosciusko |
| Showalter, John P. | Waterloo | DeKalb |
| Scott, Harry V. | Fort Wayne | Allen |
| Smith, Lowell C. | Lafayette | Tippecanoe |
| Smith, Roy L. | Indianapolis | Marion |
| Speheger, Benjamin A. | Bedford | Lawrence |
| Stern, David H. | Hammond | Lake |
| Stouder, Charles E. | Gosport | Owen |
| Strange, Martin B. | New Albany | Floyd |
| Szabo, Stephen A. | East Chicago | Lake |
| Vance, Walter H. | Fort Wayne | Allen |
| VanKirk, George H. | Kentland | Newton |
| Velkoff, Metodi | Fort Wayne | Allen |
| Venis, Kemper N. | Muncie | Delaware |
| Viney, Charles L. | Logansport | Cass |
| Warfel, Frederick C. | Indianapolis | Marion |
| Washington, G. Kenneth | Indianapolis | Marion |
| Weddle, Charles O. | Lebanon | Boone |
| Weinstein, Edwin B. | Richmond | Wayne |
| Weiskopf, Henry S. | Gary | Lake |
| Welborn, Mell B. | Evansville | Vanderburgh |
| White, Robert E. | Anderson | Madison |
| Wilmore, Ralph Clements | Indianapolis | Marion |
| York, Arthur Franklin | Anderson | Madison |
| Young, Gerald S. | Muncie | Delaware |

# INDIANA'S HOSPITAL SURVEY

Senate Bill No. 51, passed by the Indiana General Assembly during its last session, directed the Indiana State Board of Health to make a survey of all hospitals and health centers in the state. In accordance with this directive, regional meetings have been planned for the purpose of informing hospital directors of survey procedures.

Hospital directors located in Councilor Districts 6 and 7 of the Indiana State Medical Association will meet at Indianapolis on October 16, and those of Districts 8, 11, and 12 will convene in Fort Wayne on October 18. Directors in Districts 3 and 4 will meet at New Albany on October 23, and those in Districts 1 and 2 at Evansville on October 25. On October 29 a meeting will be conducted in Lafayette for the directors of Districts 5 and 9.

# Military News

After spending a leave at his home in Indianapolis, Captain Bernard Hyman has gone to the Replacement Pool at Billings General Hospital, Fort Benjamin Harrison, for reassignment.

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The latest address for Major Fielding P. Williams, of Huntington, is Camp Atterbury, Indiana. He was formerly overseas with the 69th Field Hospital.

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Lieutenant Roy V. Pearce, of Indianapolis, has completed twenty-three months of duty aboard ship, and is expecting to return to the United States. He was in Portland, Oregon, in August, while his ship was undergoing yard overhaul.

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Lieutenant Colonel Carl S. Culbertson, of South Bend, has returned home for a thirty-day leave. He has been overseas with the 32nd General Hospital, and wears the ETO service ribbon with four battle stars.

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Major Emory H. Hall, of Dunkirk, recently returned to the United States after thirteen months in New Guinea and the Philippines, and is now on duty at the Nichols General Hospital, at Louisville. Kentucky.

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Major Alan L. Sparks, of Indianapolis, has been home on a thirty-day leave. He spent thirteen months in England with the 111th General Hospital, where he was chief of the EENT Service and chief of the Laboratory Service.

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Captain L. B. Chambers, of Union City, is now attached to the *U.S.S. Thistle*, a hospital ship based at the New York Port of Embarkation. Captain Chambers recently returned from a trip to France to evacuate wounded. He spent three years in California before going to New York.

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For the past sixteen months Captain John H. Alward, of South Bend, has been stationed at the Sioux Falls Army Air Field as chief of anesthesia and also as assistant orthopedic surgeon, working with Major James M. McBride, who is a 1930 graduate of the Indiana University School of Medicine.

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Major I. J. Raphael, of Evansville, is recovering after a major operation at the Galesburg General Hospital, Galesburg, Illinois. Major Raphael has been in the Army four years, and spent thirty-two months of that time as commanding officer of a base hospital in New Guinea.

Major A. Ward Bloom, of Marion, is now stationed at the Separation Center at Camp McCoy, Wisconsin, having gone there from Camp Butner, North Carolina.

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Lieutenant Evart Malcolm Beck, of Indianapolis, is now on duty at the Naval Base Hospital, at Norman, Oklahoma.

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Captain Irvin Caplin, of Indianapolis, is at the Aviation School of Medicine, at Randolph Field, San Antonio, Texas. His previous address was a New York A.P.O.

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On duty as the Convalescence Training Officer of the First Air Force, Major David L. Smith, of Indianapolis, is stationed at Mitchell Field, New York.

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After having served for four and one-half years overseas in the C.B.I. Theatre, Captain Floyd T. Romberger, of Lafayette, has returned to this country on leave.

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Captain James B. Warriner, of Indianapolis, has recently been appointed as the 24th Division Artillery Surgeon. He is stationed in the Davao Sector, in the Philippines. He wrote that Captain Franklin M. Bryan, of Indianapolis, is also stationed nearby.

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Captain Max M. Gitlin, of Bluffton, who until recently was chief of the Surgical Service at the Station Hospital, Camp White, Oregon, and now on duty at the Veterans Hospital, Portland, Oregon, was married to Miss Mary Lawson, of Seattle, Washington, on August 16, 1945.

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Captain Raymond D. Miller, of Indianapolis, has just recently returned to the United States after spending twenty-eight months in Europe as flight surgeon with the 94th Bombardment Group. After spending a thirty-day leave with his family he reported for reassignment but instead received his separation papers on September eighteenth.

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After a year and a half with the Fourth Auxiliary Surgical Group as neurosurgical consultant, Major C. B. Fausset, of Indianapolis, has been home on a thirty-day leave. Major Fausset gained some valuable experience in Europe, although not all of it was medical—being interested in flying, it must have been a privilege to fly B-17's, C-47's, and L-5's as guest pilot. Major Fausset wears the ETO ribbon with five battle stars.

At last we have the good news for which we have all been eagerly waiting, that two more Indiana physicians have been liberated from Japnese Prisoner-of-War Camps, and are being returned to this country: Captain Nelson N. Kauffman, of Indianapolis, was captured on Bataan, and was released from Niigata, and Lieutenant Basil B. Dulin, of Mitchell, was captured in the Philippines, and released from Ashio. Both were reported to be in good health.

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Major Donald Grillo, of South Bend, has been awarded the Bronze Star for his work in the activation and evacuation of his station hospital at Kweilin, China. At the last report, Major Grillo was en route to the United States, after many months overseas' duty in the China-Burma-India Theatre. He has been in the service since July, 1942.

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We have recently learned that Lieutenant Colonel Robert A. Smith, of New Castle, is chief of the eye, ear, nose, and throat section at the Fitzsimons General Hospital, in Denver, Colorado.

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Lieutenant Colonel George E. Iterman, of New Castle, is on duty at the Station Hospital at Fort Stevens, Oregon.

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Lieutenant Colonel Orval J. Miller, of Fort Wayne, is commanding officer of the 106th General Hospital, which has one of the finest records of successful treatment in the European Theatre. There were only four deaths in more than seven thousand men sent there from the battlefronts. Also on duty with that hospital is Captain Joseph L. West, of Indianapolis.

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Captain Richard C. Miller, of Indianapolis, is the flight surgeon at an air evacuation stopover from France and Casablanca, and has been on duty there for seven months. He has been in air evacuation work about one and one-half years, having been stationed at Presque Isle, Maine, for about a year. Captain Miller stated that the work had in the past been very interesting, but now that most patients had already been evacuated it was rather dull, and he was expecting to be moved before long.

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The Bronze Star Medal for meritorious achievement in connection with military operations has been awarded to Lieutenant Colonel Sydney L. Stevens, of Indianapolis. The official citation accompanying the award stated that "during the movement of his division he directed the treatment of the wounded and sick with outstanding efficiency." Colonel Stevens is on duty with the 89th Division.

**ERRATA**

Word has been received from Mrs. Joe H. McCool, of Evansville, that she was a little surprised to read in the last JOURNAL that her husband, Captain McCool, was at Camp Bowie. She further says, "I wish he were!" We apologize for this error, which, however, was beyond our control as we had definitely received notification to that effect on a change-of-address card. Captain McCool went overseas in July of 1944 with the 111th Evacuation Hospital, and has served in Holland and Germany, being near Hamburg when the war ended. However, he hopes to be home soon.

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After more than three years in the Army Medical Corps, Major Harold C. Adkins, of Indianapolis, has been placed on inactive status and will receive his discharge in November. Major Adkins was on duty with the 437th Troop Carrier Group, and received the Presidential Unit Citation. He also has the European Theatre Ribbon with seven campaign stars.

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Located in a large city, in a modern, fireproof building, Dr. Earl E. Parker, of South Bend, feels that their hospital building is going to be one of the prizes of the Pacific when the minor damage it suffered is repaired. The hospital is the 80th General, but at present is acting as an evacuation hospital. It has been receiving casualties within two or three hours of injury, sometimes in even less time.

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In a letter written shortly before V-J Day, Major Chet Lamber, of Indianapolis, states that they are very much in a state of elation, and that hopes of being home soon are taking form. He further states: "Enclosed is a photo of Chinese and American officers taken during a presentation. The Chinese Hospital presented our unit with a banner as a token of appreciation of our cooperation and service. Since I am the C.O. of this unit of the 27th, it is being handed to me by their C.O. How about my tan? Best they get me out of China soon, don't you think, lest there be a mistake in identity!"

*Chinese token presented to Major Lamber's Unit.*

Captain W. E. Jenkinson, of Mount Vernon, has been home on a thirty-day leave, at the end of which he rejoined the 176th General Hospital, which has been sent to Camp Seibert, Alabama, for disposition. Formerly with the 85th Field Hospital, he left the United States on February 11, 1945, and landed in Liverpool a week later. Shortly after that they landed at Le Havre, then went through northern France into Belgium and finally set up their hospital in Germany. In Putzschen, Germany, they took over a German Catholic Hospital, which was operated as a station hospital for eight weeks, and then turned it over to the 65th Field Hospital. They then moved on to the Marsailles staging area where they prepared to go to the Pacific. However, while at Marsailles, Captain Jenkinson was transferred to the 176th General Hospital.

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After spending a thirty-day leave in Garrett, Captain R. A. Nason has reported to the Seymour Johnson Field, North Carolina. Captain Nason is flight surgeon for the 409th Bomb Group, which was flying A-26's. One of their first targets upon arriving overseas was the V-bomb launching ramps on the Coast of France. Captain Nason states that they had no reports of any of their airmen having trouble with the regular German army or air corps when they were forced down behind enemy lines, except that the food was bad, but the men were mistreated and even shot when captured by SS troops or German civilians and children. He stated that he thought the German children were the worst of all—that all of them seemed to have a gun, and that they would fire at American airmen as they were floating to the ground. In addition to the Air Medal, Captain Nason has the ETO ribbon with six battle stars.

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The Bronze Star Medal has been awarded to Major Milton Omstead, of Petersburg, for meritorious achievement in providing emergency care to the sick and wounded internees of Santo Tomas University. Major Omstead was part of an advance medical group that entered the Santo Tomas Internment Camp, in spite of bitter fighting that raged in the streets, to administer skilled medical care to thirty-seven hundred American and Allied civilian internees, who were suffering from malnutrition and illness. Ten of the nineteen months Major Omstead has spent overseas have been in New Guinea, where he was at Milne Bay, and later at a front-line hospital in Sensapore. The troopship on which Major Omstead was going to New Guinea was wrecked on a reef in the China Straits, off the coast, and he and the rest of the hospital personnel were forced to abandon ship and make their way to shore in small boats. Major Omstead is now in charge of the Dispensary and Outpatient Department of the 49th General Hospital in Manila.

The Bronze Star has been awarded to Lieutenant Commander M. L. Connerley, a member of Indianapolis (Marion County) Medical Society, for "achievement in action" on Guam. Commander Connerley was wounded on July 22, 1944, when a Jap mortar shell hit the edge of a foxhole which he and a Marine officer were occupying. Upon regaining consciousness, Captain Connerley cared for his own wounds and those of the Marine officer. He was returned to active duty, and on August tenth his patrol killed three of the enemy and captured valuable papers. Commander Connerley is now on duty as chief of surgery at the Naval Training Hospital, at Newport, Rhode Island.

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Major Ralph U. Leser, of Bloomington, recently returned from Europe, and while on a thirty-day leave stopped in to see us. (We are, indeed, pleased to have our returning physicians call at THE JOURNAL office, and we hope that more will do so upon their return.) Major Leser told us that he was in his fifth year of Army duty, thirty-eight months of that time having been spent overseas. His first overseas assignment consisted of more than twenty-two months of duty in Panama, where malaria, heat, skin afflictions, and rare tropical diseases were the chief conditions which plagued the soldiers. He was assigned to the Fort Clayton Station Hospital, and later was camp, battalion, and regimental surgeon for Panama's Air Warning (Radar) Regiment, which was scattered all over the Isthmus of Panama on jungle hill-tops and on lonely islands, necessitating trips by native boats, jeeps, trucks, small planes, on horseback, and on foot. Landing fields were, for the most part, on beaches and in cowpastures.

Major Leser then returned to the United States for six months. In April, 1944, he was sent overseas again, this time with the 185th General Hospital, where he was assistant chief of the medical service, and chief of gastro-enterology. This unit was stationed in tents, and later in Nissen huts in England, and its function was to care for casualties which were brought by LST boat and later by plane from the Continent. The worst period occurred during the St. Lo fighting when six hundred badly-wounded men were brought into the hospital in thirty-six hours.

After a time, Major Leser was sent to Germany to serve with the 300th Provisional German Hospital Center, which cared for German prisoners of war. This organization was under Adsec (Advance Section of Communications Zone), which supplied the First, Third, and Ninth Armies. The headquarters of the 300th was in Bad Nauheim, and it was there that Major Leser saw Captain Jake Gillespie, of Indianapolis, who was a squadron surgeon with the 19th Tactical Air Force of General Patton's Third Army.

On August eleventh Major Leser returned to the United States for a thirty-day leave, at the end of which time he reported to Fort Devens, Massachusetts, for reassignment.

Captain James S. Walker, of Indianapolis, is chief of the ear, nose, and throat section of the 59th Station Hospital, in the Philippines. He has been overseas thirty-eight months. Captain Walker has recently been awarded the Bronze Star Medal for "thirty months meritorious service with the 46th Engineers, and treated wounded under enemy fire during the landing on Leyte, in October, 1944. He has participated in five major campaigns. During the fighting on Biak, Captain Walker acquired a Japanese medical officer's diary, first aid kit, sterilizer, and his characteristically myoptic eyeglasses. The equipment proved to be of excellent quality; the medicines were contained in glass vials inside aluminum covers, and the ampules have both Japanese and English names on them. The diary was interesting, too—it stated that the Japanese were on a small island just off the coast of New York. All this time we have thought Biak was off the coast of Dutch New Guinea!

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We wish to quote a letter from Captain L. C. Bixler, of South Bend, which was published in the St. Joseph Medical Society *Service Bulletin:*

"The Army is still conducting me on this Cook's Tour around the world. Since writing last from Aachen, we have had another cross-country '40 and 8' trip, and are now in southern France in the Marseilles area. We are in what is variously known as a staging area, rest camp, and dust bowl, the latter being the most applicable. Of course, we have all of the comforts and conveniences of living in tents, plus the fun of camping out — — the last thing I'll ever do when I get back to civilian life is go on a camping trip. Marseilles is fairly near, and big army trucks go to the city frequently. It is a very old, big, and dirty city. Each block has a different odor, and none of them is good. We have taken a boat ride through the harbor, including a trip to the island on which the chateau is located, where the Count of Monte Cristo was imprisoned in Dumas' book. The Mediterranean is as clear as crystal, and a beautiful blue, but chilly. The weather here is well nigh perfect, and well it should be, this being on the brink of the famed Riviera. Such a succession of clear, sunny, warm days and cool starry nights I have never seen. Carl Culbertson has left the 32nd, and is now in this camp attached to another general hospital. 'Hink' Proudfit is also here."

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When Captain Roy A. Geider, of Indianapolis, left the United States in December, 1942, he probably had no idea of the experiences in store for him. Seven battle stars, a bronze Arrow Head, denoting participation in a beach landing, and five overseas stripes are certainly an indication that they must have been numerous and varied.

After leaving here in December, 1942, Captain Geider went to England, and was there about two months, during which time he was at Oxford, doing special work in British hospitals. When asked his opinion of British hospitals, Captain Geider said that he had nothing but admiration for them. He said that on the whole their medical standards were lower than ours, but he thought that was due in part to the fact that they had been running beyond their capacity for so long. He stated, "They get more done in less time, with less help and less griping then anywhere I have ever seen."

From England he went to Oran, and then up to Tunisia with a surgical team attached to the British First Army. He stayed with this team throughout the Tunisian campaign, and then came back to Bizerte, where they prepared for the invasion of Sicily, this time attached to the Third Division of the United States Army. They entered Sicily on D-day with an advance party of a field hospital, and for the first two days worked with a clearing station on the beach. Then throughout the remainder of that campaign he worked with a field hospital. After Sicily he returned to England with the divisions that made up the nucleus of the American First Army, which was organized in England. During this period he worked as an anesthetist with the 38th Station Hospital, at Winchester, and as an instructor in anesthesia in an Army school near Bristol.

Going in on D-Day plus four on the Omaha Beach in the invasion of France, Captain Geider again worked with clearing stations on the beaches, and, following the wake of the advance, again worked with field hospital platoons alongside clearing stations three to five miles behind the front—all this work being done as a member of a surgical team.

Following the Normandy campaign, they went across France into Belgium, and then into Germany. Captain Geider was in Germany for the first time in November, 1944. He was at Roentgen, Germany, at the time of the Bulge. They later worked at the northern edge of the Ardennes throughout that campaign, then proceeded into Germany again the last of January. This time they went through to the Roer River. After the taking of Duren they pushed on to the Rhine, crossed the Rhine at the Remagen Bridgehead, and finally advanced into central Germany.

The first of April he was transferred to the 178th General Hospital, at Rheims, France, where he was chief of anesthesia, and in charge of the operating rooms. He was at Rheims at the time of the signing of unconditional surrender by the Germans.

After thirty-two months overseas, he was transferred to the United States on the thirtieth of July, being transported by plane. During his thirty-day leave Captain Geider received his orders for separation, and has since been very busy with his practice of medicine, which he resumed on September first.

# Deaths

**Victor Vernon Cameron, M.D.,** of Marion, died September third after an illness of several years. He was sixty-nine years of age. Doctor Cameron was a graduate of the Baltimore Medical College, in Baltimore, Maryland, in 1899. He had retired from practice.

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**Renos Harlan Richards, M.D.,** of Patricksburg, died September ninth at the age of sixty-nine. At the time of his death Doctor Richards was serving as president of the State Board of Beauty Culturist Examiners, and as chairman of the State Medicine and Public Health Committee in the House of Representatives, of which he had been a member for four sessions. Doctor Richards had practiced medicine in Owen County since his graduation from the Central College of Physicians and Surgeons, in Indianapolis, in 1903, and had served as treasurer and coroner of the county, and as president of the Owen County Medical Society. He was a veteran of World War I, having served as a major in France, and later on the Mexican border. He held the rank of lieutenant colonel in the Medical Reserve at the time of his death, and had, in the past, been a member of the Indiana National Guard. He was a member of the Owen County Medical Society, the Indiana State Medical Association, and the American Medical Association.

*R. H. Richards, M.D.*

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**Oscar Clinton Wainscott, M.D.,** of Peru, died September third at his home. He was seventy-five years of age. Doctor Wainscott was a graduate of the Bellevue Hospital Medical College, in New York, in 1896. He retired from practice about ten years ago.

**Daniel Walter Sheek, M.D.,** of Greenwood, died on August twenty-eighth at the age of seventy-four. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1903.

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**George G. Van Mater, M.D.,** of Peru, died at a local hospital on August twenty-ninth. He was eighty-two years of age. Doctor Van Mater graduated from the New York Medical College, in New York City, in 1892.

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**Bine Whitlatch, M.D.,** of Milan, died on September ninth of a heart ailment. He was seventy years of age. Doctor Whitlatch was co-founder of the Whitlatch Clinic, in Milan, beginning his practice there in 1913. He was a graduate of the Kentucky University Medical Department, in Louisville, in 1905. Doctor Whitlatch was a member of the Ripley County Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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**William L. Wilson, M.D.,** of Scipio, died August twenty-eighth at his home after a prolonged illness. He was eighty-five years of age. In spite of his advanced years, Doctor Wilson maintained his office practice until a short time before his death. He had practiced in Scipio for fifty years, and had practiced before that in Spiceland, making a total of about sixty-four years as a practicing physician. Doctor Wilson was a member of the Jennings County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**Richard Burtch Gannon, M.D.,** of Gary, died on September twentieth at a local hospital, from a lingering illness. Doctor Gannon was forty-one years of age. He was a graduate of the Loyola University School of Medicine, in Chicago, in 1937, and had practiced since that time in Gary. He was associated with his father, Dr. George W. Gannon. He was a member of the Lake County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**Thomas E. Courtney, M.D.,** of Indianapolis, died on September twenty-seventh at a local hospital. He was seventy-seven years of age and had practiced medicine for fifty-three years. He graduated from the Central College of Physicians and Surgeons in 1892, and had taken postgraduate work in Germany. Doctor Courtney was a member of the Indianapolis Board of Health and the Indiana State Anatomical Board. He was also a member of the Indianapolis (Marion County) Medical Society, an honorary member of the Indiana State Medical Association, and a Fellow of the American Medical Association.

# News Notes

The Madison County Board of Commissioners have named Dr. O. A. Kopp, of Anderson, as physician for the county jail. He succeeds Dr. John C. Armington, and will serve until January 1.

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Drs. C. F. and J. M. Kercheval have discontinued their practices in Clinton, and will return to Indianola, Mississippi, where they will practice general surgery.

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Dr. John H. Kneidel and Miss Jean Lou Foley, both of Indianapolis, were married July fourteenth at a Presbyterian Church in Indianapolis. Dr. and Mrs. Kneidel are residing in Muncie, where Doctor Kneidel is an intern at the Ball Memorial Hospital.

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Dr. Richard Bruce O'Bryan, of Columbus, and Miss Mary Alice Pesch, of Plymouth, were married on August twenty-fifth at the St. Michael Church, in Plymouth. Dr. and Mrs. O'Bryan will reside in Indianapolis, where Doctor O'Bryan is serving his internship at the Indiana University Medical Center.

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### AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next written examination and review of case histories (Part I) for all candidates will be held in various cities of the United States on Saturday, February 2, 1946, at 2:00 P.M. Candidates who successsfully complete the Part I examination proceed automatically to the Part II examination held later in the year. All applications must be in the office of the Secretary by November 1, 1945.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

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Dr. O. B. Nesbit, of Gary, is again associated with the Public School Medical Inspection Department, which he established many years ago. Doctor Nesbit had retired, but with the resignation of Dr. Mattie Bullard, who entered the United Nations Relief and Rehabilitation Administration, he consented to serve again until a full-time physican can be found.

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It has been announced that Dr. James D. Peirce, of Indianapolis, has been appointed a member of the City Merit Commission. Doctor Peirce will fill the unexpired term of the late Dr. John A. M. Aspy, whose term would have expired on January 1, 1948. The commission passes on the eligibility of applicants to the Indianapolis Police and Fire Departments.

After thirty-eight months' service in the United States Army Medical Corps, Doctor Ben B. Raney, of Linton, has been released, and has resumed his practice in Linton, at 129 East Vincennes Street.

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Dr. Nevin E. Aiken and Miss Barbara Botts, both of Fort Wayne, were married on July ninth, at the First Presbyterian Church in Fort Wayne. Doctor Aiken graduated from Indiana University School of Medicine in 1943.

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Dr. James F. Peck, of Princeton, and Miss Mary Evelyn Edgington, of Indianapolis, were married at the United Presbyterian Church in Princeton, on September 2, 1945. Dr. and Mrs. Peck will reside in Norfolk, Virginia, where Doctor Peck will serve his nine-months' internship at the Marine Base Hospital.

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After more than three years in the service, Captain Forest M. Kendall, of Alexandria, has been released. Entering the service in July, 1942, Captain Kendall was stationed in Corsica for almost a year, and then went on into Italy. He was on duty as flight surgeon for a medium bombardment squadron.

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Dr. Jonathan G. Yoder has returned from Dhamtari, India, where he has served for the past eight years as a medical missionary, and has taken over the practice and office building of the late Dr. W. B. Page, in Goshen. Dr. Yoder returned on the *Gripsholm*, arriving in Jersey City on August second.

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### ELEVENTH INDIANA COUNCILOR DISTRICT

The Eleventh Indiana Councilor District Medical Association will hold a meeting in Delphi, on October seventeenth, with the program beginning at 2:00 P.M. The program will be as follows:

1. Short business session.
2. Inaugural Address, by Paul W. Ferry, M.D., Kokomo.
3. "Newer Concepts of Glandular Therapy," by John H. Hutton, M.D., Chicago. General discussion.
4. "Cervical Dislocation in General Practice," by E. B. Jewell, M.D., Logansport. General discussion.
5. "Office Orthopedics," William V. Woods, M.D., Indianapolis. General discussion.

Members of the Indiana State Medical Association, especially those of nearby counties, are invited to attend.

*(Continued on page xxix)*

*(Continued from page 438)*

Abe Leff, M.D., of Indianapolis, has opened an office at 712 East Fifty-second Street, for the practice of medicine.

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Dr. Thomas C. Hall, formerly of Medaryville, has moved to Chesterton, and has entered into partnership with Dr. J. W. Dale of that city.

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A recent letter from Dr. F. E. Keeling, of Portland, states that he is on his terminal leave from the Army, and will soon reopen his office in Portland.

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After almost five years in the service, Major Ernest L. Dietl, of South Bend, has been released from service. He has recently returned from the European Theatre.

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Dr. Earl W. Mericle, of Indianapolis, has established offices with Dr. Philip B. Reed, at 817 Hume Mansur Building, for the practice of neuropsychiatry. Dr. Mericle has recently returned from the service, having served as neuropsychiatrist with the Fourth Armored Division. He held the rank of Major. Doctor Mericle entered the service in January, 1941. His decorations include the Bronze Star and the Legion of Merit.

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A one-day meeting for base surgeons of the I Troop Carrier Command at Stout Field, Indianapolis, on August twenty-fourth, was climaxed with a dinner at the Severin Hotel, in Indianapolis, with Colonel R. J. Benford, Command Surgeon, as host. The principal speaker was Lieutenant Colonel Truman G. Blocker, chief of the Plastic Surgery Section at the Wakeman General Hospital, at Camp Atterbury, who discussed recent developments in this field.

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At a reorganization meeting of the Indiana Division of the American Cancer Society, at the Indiana World War Memorial, in Indianapolis, on September sixteenth, Drs. Thurman B. Rice, Chester A. Stayton, and C. G. Culbertson, all of Indianapolis, were named as vice-presidents. The newly-elected president is Mr. William H. Ball, of Muncie. Persons attending the meeting elected the new name, Indiana Division of the American Cancer Society, to replace the former name of the Indiana Field Army of the American Cancer Society.

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Dr. Albert L. Marshall, Jr., has announced his association with Dr. L. A. Ensminger, 908 Hume Mansur Building, Indianapolis, for the practice of orthopedic surgery. Dr. Marshall was recently retired from the Army Medical Service, having been on duty since January, 1941. The first two years he was regimental surgeon with the 38th Division. He was then transferred to the 29th Evacuation Hospital, as chief of the Orthopedic Section. They were stationed in the Southwest Pacific.


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TEACHING FACULTY—ATTENDING STAFF OF COOK COUNTY HOSPITAL.

Address: Registrar, 427 South Honore Street, Chicago 12, Illinois

Dr. John E. Graf, of Chicago, who is seventy-two years of age, and who has served as physician and surgeon in the Coast Guard Training Reserve, in Illinois, for three years, was "mustered-out" of the Coast Guards the last of July. Doctor Graf was formerly in charge of the EENT Department of the Veterans' Hospital, in Indianapolis.

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Dr. Robert E. Neff, nationally-known hospital administrator, has recently been appointed superintendent of the Methodist Hospital, at Indianapolis, and will assume this position in about two months. Doctor Neff served for several years as administrator at the Indiana University Hospitals, prior to 1928, when he left to become administrator of the Iowa University Hospitals. Doctor Neff succeeds the Reverend Orien W. Fifer, who has been the acting superintendent since the resignation of Dr. John Benson last spring.

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On August eighth, Dr. R. M. LaSalle, of Wabash, was separated from the service. He had served as a lieutenant colonel in the European Theatre of Operations. During the invasion of Southern France, Doctor LaSalle was on duty at Port No. 10, each port really being a harbor, such as Le Havre. He stated that at one time there were ten thousand vehicles, including everything from jeeps to heavy tanks, at his port. His duty was to supervise the medical supplies for this entire port. He stated that in the invasion there were about four thousand ships. Doctor LaSalle has reopened his office at 55 West Market Street, for the practice of medicine.

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## INDIANA UNIVERSITY NEWS NOTES

Experience acquired in military service by recently-graduated medical students gives assurance of competent medical service, according to the opinion of Dean W. D. Gatch, dean of the Indiana University School of Medicine.

"Reports to the Indiana University School of Medicine from its recent graduates who have served in the armed forces during the war indicate that they have met tests and have had experiences seldom found in a lifetime of civilian practice," Dean Gatch said, who to illustrate his statement made public a letter received from Captain Charles A. Walters, of Mishawaka, who was graduated from the Indiana University School of Medicine in 1939.

"We have spent twelve hours a day in operating," Captain Walters reported, in discussing the medical side of the American invasion of Okinawa. "A great many days I operated sixteen hours continuously, with an hour or two of rest at the end of an eight-hour period. Our operating schedule covered the entire twenty-four-hour period. Each doctor operated individually, having an enlisted man as assistant. Often at night our surgical lights failed, and it was necessary to finish an abdominal case by means of a flashlight."

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Indiana University, through its Bureau of Audio-Visual Aids, headed by Professor L. C. Larson, has produced a motion picture which has won the plaudits of the American College of Surgeons and the United States Coordinator of Inter-American Affairs. The picture, "The Effects of Metallic Ions and Osmotic Disturbances," made by the bureau in cooperation with Dr. K. G. Wakim, professor of physiology in the University's School of Medicine, has been recommended by the College of Surgeons as having "special value in teaching students in the sciences, including medical students," and the Inter-American Affairs office plans to circulate the film in the other American republics as an illustration of the scientific progress of the United States.

Approval by the two agencies is regarded by university officials as giving additional impetus to its production of educational films, which the war has demonstrated are important teaching aids. Several films previously produced by this bureau have won wide acceptance.

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Preparing for the return of numerous physicians from military service, as well as to care for the needs of many doctors prevented in wartime from doing further study, the faculty of the Indiana University School of Medicine has outlined a five-fold program of postgraduate instruction designed to provide the much-desired refresher work.

In announcing the program, Dean W. D. Gatch pointed out that from inquiries already received it has been discovered that the requirements of the applicants are too varied to be met by a single refresher course, and that the work is therefore being divided into five classifications:

A general review of the entire subject of clinical medicine, consisting of lectures and dry clinics, for the general practitioner with limited time for postgraduate study.

A thorough course in the basic sciences of anatomy, applied physiology, and pathology, designed for those preparing for national board examinations, and requiring at least six months' study.

Extern work in the university and city hospitals with students in residence on the university campus, doing work similar to that of the university's senior externs, and comprising from three to six months' training.

A continuation of the established program for training residents at the Medical Center.

Extension courses to be given at hospitals in various parts of the state. The medical school last year conducted such an extension program at St. Elizabeth's Hospital, in Lafayette, and requests for similar schools have been received from hospitals in other sections of the state.

# Smoothage IN COLITIS MANAGEMENT..

METAMUCIL

*Metamucil is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois*

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

The demulcent smoothage effect of Metamucil makes it a valuable adjunct in the various forms of colitis—spastic, atonic and ulcerative.

The tendency of Metamucil to incorporate irritating particles within the intestinal residue assists materially in minimizing irritation of the inflamed mucosa.

*Smoothage* describes the gentle, non-irritating action of Metamucil—the highly refined mucilloid of a seed of the psyllium group, Plantago ovata (50%), combined with dextrose (50%).

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

"The purpose of these courses," according to Dean Gatch, "is to make hospitals of 150 beds, or more, teaching centers, conducted by faculties elected by the hospital staffs." This plan is designed to give every physician the opportunity for continuous postgraduate work in his home community.

The above program has already been started, but with an undermanned staff and facilities crowded to capacity much of the plan must await greatly-needed expansion.

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At the August 19 commencement of Indiana University, the following 101 men and women received the Doctor of Medicine degree:

James A. Alford, Garrett; Charles R. Alvey, Muncie; Arthur M. Antonow, Terre Haute; Roy J. Ault, Terre Haute; Harry W. Banker, Portland; William G. Bannon, Kokomo; Edwin N. Barnum, LaPorte; Robert C. Bartlett, Bloomington; Robert A. Beck, Terre Haute; Charles D. Benedict, Vevay; Louis H. Blessinger, Huntingburg; Jesse F. Brown, Whiting; Thomas C. Brown, Sullivan; Fred S. Carter, Hammond; Paul V. Chivington, Jr., Indianapolis; Jack W. Clarke, Bristol; Floyd B. Coleman, Martinsville; Richard M. Craig, Fort Wayne; William W. Dalton, Clay City; Paul G. Donner, Columbus; Jordan H. Doran, Burket; Mrs. Louise Foster Eaton, Bloomington; Tom H. Ebbinghouse, North Manchester; John Ellett, Jr., Coatesville; Wayne H. Endicott, Indianapolis; Vernon O. Erk, Richmond; Daniel W. Everett, Indianapolis; R. Ross Fowler, Bloomington; Craig W. Freeman, Anderson; Forrest W. Freeman, Anderson; James L. Garrison, Lawrence; Robert L. Haller, Fort Wayne; Charles O. Hamilton, Selma; Howard T. Hammel, Monon; Arthur K. Hamp, Kokomo; Robert W. Harger, Indianapolis; Verne K. Harvey, Jr., Indianapolis; George M. Haymond, North Manchester; Mrs. Phyllis Gill Hillsamer, Bloomington; Ainslee A. Hood, Alexandria; Paul S. Jarrett, Sharpsville; Paul D. Johnson, Jr., Terre Haute; Wilbur L. Kenoyer, Anderson; William F. Kerrigan, Connersville; Joseph G. Klotz, Noblesville; John H. Kneidel, New Castle; Robert P. Knowles, Indianapolis; Thomas A. Koons, Muncie; Charles A. Labotka, Hammond; James F. Land, Kokomo; Leonard M. Lasser, Gary; Robert H. Leak, Williamsport; Harold B. Lehman, Berne; Kenneth M. Lehman, Goshen; Forrest C. Leiter, Rochester; Joseph J. Littell, Jr., Indianapolis; William J. Little, Bicknell; Leon M. Liverett, Indianapolis; Edwin S. McClain, Franklin; Harold M. Manifold, Ingalls; Michael W. Manzie, Hoboken, New Jersey; Bill L. Martz, Anderson; Melvin Matlin, Brooklyn, New York; John E. Meihaus, Indianapolis; John H. Mertz, Indianapolis; J. Martin Miller, Indianapolis; William J. Miller, Fort Wayne; George M. Murphy, Franklin; Paul W. Myers, Indianapolis; Eugene Newby, Sheridan; Robert J. Nichols, Knox; Richard B. O'Bryan, Columbus; George E. Paine, Elkhart; James F. Peck, Princeton; Thomas A. Petty, South Bend; Glen A. Ramsdell, LaPorte; Robert L. Raphael, Evansville; Eugene S. Rifner, Spiceland; Jordan C. Ringenberg, Woodburn; William C. Robertson, Indianapolis; Bertram S. Roth, Muncie; Marshall J. Rowdabaugh, Warsaw; William K. Saint, New Castle; Joseph V. Schetgen, New Castle; Donald M. Schlegel, Brazil; Eugene E. Schmidt, Fort Wayne; John E. Schreiner, Anderson; Joseph W. Sibbitt, Frankfort; Robert M. Squire, Lyons; Ben O. Stands, LaFontaine; Ralph M. Steffy, Logansport; Karl Stillwater, Detroit, Michigan; Joseph S. Stratigos, South Bend; Donald Taylor, Wheeler; Lloyd S. Terry, Coatsville; William E. Van Fleit, Garrett; James M. Wagoner, Huntingburg; William A. Walter, Jr., Gary; John D. Wilson, Evansville; Donald A. Zalac, Indianapolis, and Dan Zavela, Indianapolis.

# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION

### BUREAU OF PUBLICITY

August 20, 1945.

Present: H. G. Hamer, M.D., chairman; Ray E. Smith, assistant executive secretary and secretary of the bureau.

The assistant executive secretary reported that as a result of the survey seventy-four weekly newspaper had ordered the "Hinths on Health" column to date. It was decided to start the column the week of August 27, 1945, and column news releases for three weeks were approved, as follows:

Week of August 27, 1945—"Poison Ivy."

Week of September 3, 1945—"Avoiding Typhoid Fever."

Week of September 10, 1945—"Insect in the Ear."

Requests for speakers:

August 31 — Optimists' Club, Indianapolis. Speaker obtained to talk on socialized medicine.

March, 1946—Woman's Auxiliary to the Fort Wayne Medical Society, Fort Wayne. Request for speaker on "Health Plans for 1946." Speaker obtained.

Action of the Chairman of the Committee on Mental Health in calling his committee and speakers into meeting at the Columbia Club on Sunday, September 9, was reported by the bureau secretary.

A letter from Harold F. Brigham, director of the Indiana State Library, offering to house minute books of county medical societies, which must be moved from the Indiana University Medical Center, was read. A copy of Mr. Brigham's letter was ordered sent to the chairman of the Committee on Necrology and History, requesting an expression from him on the subject. Action was postponed until the next meeting.

Material on the Wagner-Murray-Dingell Bill was considered. Copies of the material were distributed to members of the bureau for study.

Letters received from two commercial firms, explaining their inability to sponsor "Dr. Goodhealth" radio programs, were read and filed.

Write for your

reservation now for

the annual meeting,

November 6, 7, and 8.

# THE JOURNAL
OF THE
# INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

*ISSUED MONTHLY under Direction of the Council*

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 38 NOVEMBER, 1945 NUMBER 11


## PRESIDENT'S ADDRESS*

### INDIANA STATE MEDICAL ASSOCIATION


N. K. FORSTER, M.D.

HAMMOND


Whatever satisfaction might accrue from the presentation of this report in person was for some time a doubtful question because of the probable cancellation of our annual meeting. This was deeply regretted, not so much because of my own disappointment in not having the opportunity of appearing before you, but chiefly because it might not enable me to express to you, personally, my sincere appreciation for the honor you have delegated to me. Since the war has ended and we are able to meet again, my sense of gratitude is no less keen, and I want to thank you for having given me the opportunity to exert my efforts toward the attainment of unity of purpose and the application of sound principles for the advancement of our profession and the benefit of those we are permitted to serve. No one person, no group of officers, and no body of delegates can accomplish the solution of the many problems we are facing. It is a task to which everyone of us in medical practice must be committed in a spirit of service to preserve our concept of American Medicine. Consequently, it is with considerable sense of misgiving of my own efforts in this respect, but with an enormous pride in the accomplishments of our officers, committees, and membership that I present this report to you.

#### PREPAYMENT OF MEDICAL AND SURGICAL CARE

This year of activity was initiated with the definite instruction from the House of Delegates that a prepayment plan for medical and surgical care be submitted at a special meeting of the House of Delegates. This action followed the deliberations of the House of Delegates at a special meeting in November, 1944, during which it was decided to favor an indemnity type of plan, and the president was advised to appoint a representative committee, with the advice and approval of the Council, to re-study the problems and submit their conclusions at a called meeting of the House of Delegates. Doctor Oliphant, then president, courteously asked for my suggestions, and those of the councilors, at a special meeting of this body. A committee of twenty-one members, headed by Dr. W. U. Kennedy, and representative of our membership geographically and as to kinds of practice, was subsequently appointed.

This committee has performed a heroic work. The time, energy, study, travel, correlation, correspondence, and personal sacrifice necessary to formulate the final plan have been tremendous, and for this outstanding endeavor this organization owes a deep debt of gratitude to these members. The final program has been presented at a special session of the House of Delegates, called during this state meeting to consider this matter only, and it is sincerely hoped that from the deliberations of this body there will emerge a definite, workable plan that will satisfactorily spread the cost of medical care and find enthusiastic support from the profession and the public. Certainly the action of our House of Delegates commands your respect and cooperation.

#### LEGISLATIVE PROBLEMS

The presentation of the new Wagner-Murray-Dingell Bill and, more recently, the Pepper Bill,

* Presented before the General Meeting of the Indiana State Medical Association, at French Lick, on November 7, 1945.

again emphasizes the fact that proponents of socialization of medicine are actively engaged in their efforts to break down the existing form of medical practice, and submit it to governmental regulation and control. Innumerable plans have been advocated by the extension of the EMIC program, the United States Public Health Service, Public Health Association, the old Committee of 430, and many other individual groups and organizations, to add to the turmoil of the picture. It is hoped that from this babel a final, ultimate program will evolve from the study and consideration of the medical profession itself. This is where the problem belongs, and this is where the solution should be sought and found.

It has always been difficult for us to perceive just what superior attributes are possessed by a few politically-empowered individuals that designate them as expert planners of the destiny of any group or organization whose work is founded upon the basic principle of public welfare. Nor have we been able to detect the evidence that supports the proposition that the election of an individual or a party as servants of the electors promptly endows them with a superlative wisdom and omnipotent measures to subject any association or individuals to governmental domination when their purposes and aims are not opposed to the well-being of their fellow men. Within the ranks of the profession are able, honest, conscientious, and fearless workers who can provide the answer to the problem of the adequate distribution of medical care, and can do so at a cost within the means of the affected public. The organization is set up and solvent; the desire of the profession at large is apparent; and the public need exists—it remains only for the machinery to begin operating.

The Council on Medical Service and Public Relations, of the American Medical Association, has presented a fourteen-point program of which we may all be proud, and to the achievement of this goal we should all lend active support. This program embodies practically all of the pressing issues before us. Their activation will require the cooperation of the entire medical profession and an unlimited amount of work by the state and county organizations. Our own Council on Medical Service and Public Relations has enthusiastically approved this program, and urges that every county society devote one meeting to its consideration. From all of this planning we are depending upon the good common sense of the medical profession to direct the accomplishment of sound legislation to the end that the public interests will be served and the principles of medical practice preserved.

### COMMITTEE WORK

It would be impossible to mention all of the activities representing the enormous amount of work produced by our various committees. Again our gratitude is expressed to each and every member who served on one or more of these bodies. While in so many instances this work is of a thankless nature, time-consuming and never convenient; nevertheless, it constitutes the structural skeleton of our organization, and it is the basis upon which we build for progress or lie dormant. This is no time to lie dormant! There are too many forces at work, attempting to undermine our structure, to permit any relaxation. Our organization is no longer one that can depend upon the interest of merely our Council, Executive Committee, and officers to do the work of our association—every committee member and, in truth, every individual member must become vitally concerned about the welfare of his organization and work for its success, for it actually means the preservation of his own interests as well.

During the past year letters have been sent to the chairmen of all key committees, suggesting various programs that might be considered or initiated. This was in no way intended as a directive measure, or as an infringement upon the activities of the committees addressed. It was intended as a sincere attempt to maintain interest in our state organization during very trying times, and, perhaps, as an incentive to create some definite action from the programs suggested. It continually is becoming more apparent that the medical profession is constantly on the defensive. The chief reason, of course, lies in the fact that we, ourselves, do not initiate progressive programs. Others initiate programs which in themselves are generally bad, and we are, perforce, called upon to set up defensive action. For example, the tuberculosis screening program, the EMIC program, the rehabilitation plans, and others. Under forceful, farsighted medical action all of these might have been anticipated, and the profession induced to lead the way in proposing measures over which they might have exercised some control. There still remains hundreds of ways in which we can exercise our ingenuity in first proposing and sponsoring, and later in controlling, general health measures. To ferret out, and to discuss and present such measures becomes an increasingly-important function of our committees if we are to assume the leadership in health matters and preserve our way of practice.

The most important phases for future work lie in the cooperative attitude and energy we will expend in making the fourteen points proposed by the American Medical Association Council a living, active program of constructive development and progress. Veterans' rehabilitation, physical fitness, the release of medical officers from the armed forces, the establishment of prepaid insurance plans, and a forceful power directed against bureaucratic medicine are but a few of many problems that require the paramount interest and effort of all of us. Now is surely a time when no committee or member can fail to provide the utmost interest and energy in promoting the welfare of his organization and profession.

### MEDICAL PUBLIC RELATIONS

In April the Michigan State Medical Society invited the presidents of seventeen state medical societies to attend a conference on medical legislation and public relations. As a result, a resolution was adopted, recommending that each state form a planning panel to draft measures for national legislation and improvement of medical public relations. The recommendations of each state panel are to be gathered together, and a coordinated statement of recommendations is to be presented to the Council on Medical Service and Public Relations of the American Medical Association for its action. Since that time a similar conference of ten western state presidents was held in Denver, in June, and as a result these states have joined with the original conference members, and the Committee on Medical Public Relations has been enlarged to include representatives of these states. This body is now known as the Committee on Medical Public Relations for twenty-six states. We are now advised that the New England states have formed a New England Medical Council, with similar objectives.

Originating with the Michigan State Medical Society, we are witnessing a very forward, progressive step in the organization of various state medical associations, through their presidents, into a compact body devoted to the proposition of taking an active interest in medical problems as a whole. The innovation of bringing state presidents together is a most happy one, and should be productive of better understanding and closer cooperation in the outlook upon each individual problem. We hope that this method will find national acceptance, and that it will continue. No finer approach has been made toward national medical understanding, and Michigan is to be congratulated for promoting this splendid idea.

Part of the Michigan conference dealt with the prospect of a national radio hook-up, paid for on a pro-rata basis of state membership, and commercially sponsored by the seventeen states. After due consideration our Executive Committee did not feel that it had the right to obligate Indiana in joining this hook-up without the consent of the House of Delegates, since it would involve the expenditure of some three thousand dollars for the thirteen weekly programs.

The programs, as depicted for our benefit, are a combination of good music and singing, with an interpolation of sound medical concepts and ideals. Since radio programs offer such a potent medium for the conveyance, to millions of people, of the things we want them to know, and since the cost is a nominal one in comparison to the vast audience reached, it is my recommendation that the House of Delegates give serious thought to the prospect of joining with the twenty-six states now represented in medical public relations programs, and that it give favorable consideration to the advisability of cooperating with such a national radio presentation.

In connection with the Drafting Panel for Indiana, to consider the question of good medical legislation and public relations, the Executive Committee approved the appointment of such a panel, and accordingly Drs. J. T. Oliphant, J. William Wright, H. G. Hamer, F. T. Romberger, J. E. Ferrell, C. H. McCaskey, and myself were appointed to serve. At a meeting on June 17 this panel recommended that a program be drawn up, to be presented to the Committee on Medical Public Relations for twenty-six states. This program has been completed and embodies the following twelve points for the committee's consideration:

1. We are in favor of a medical care program offering *good* medical care to all of the people, based upon voluntary participation, both by the patient and the physician, and free from all administrative direction or control by governmental agencies or bureaus.
2. We are in favor of an indemnity plan as contrasted to a service plan, based on voluntary participation, with benefits paid directly to the individuals concerned.
3. We are in favor of a medical care program which will have its inception in the various states and will be an equitable plan covering the needs of its residents. *Group cooperation*, on a national level, by these various state plans should be accomplished as soon as possible.
4. We are in favor of consumer subsidies for those in total or partial need of medical assistance, but only insofar as these grants are paid directly to the individuals concerned.
5. We are in favor of proper legislation which will direct the medical care of veterans to their own communities, with free choice of hospitals and doctors. This should be effective in relieving the government of the necessity for construction of large veterans' facilities, and will find particular favor among the veterans themselves.
6. We are in favor of close unification of all opinions relative to medical care plans, simplification of objectives, and a well-organized and united program to obviate any necessity for governmental intervention.
7. We are in favor of a broad educational program based upon cooperative meetings and discussions with teachers, ministers, industrialists, farmers, labor organizations, and all professional and lay groups seeking a common level of understanding and solution to the problems affecting the public health.
8. We are in favor of active participation, by the medical profession, in the administrative functions of hospitals, to the end that medical practice shall be protected from the encroachment of hospital attempts to

control or dictate medical practice, or to infringe thereon, and that a clear perspective may be had of the part hospitalization costs play in the total cost of medical care. In addition, there must be some control of government appointments to hospitalized cases coming under their subsidies.

9. We are in favor of the establishment of a Secretary of Public Health and Welfare, of Cabinet rank, under whose supervision *all* related matters will be consolidated and administered, and who shall be appointed from the ranks of *actively* practicing physicians.
10. We are in favor of the employment, by the American Medical Association, of a prominent lay figure in American life, at a substantial remuneration, to represent and speak for the American medical profession in *all* matters dealing with or bordering on public relations. His actions are to be guided and assisted by a consulting body of the American Medical Association, but his actual representations are to be determined by his own judgment.
11. We are in favor of complete and entire freedom from political domination of medical practice, in any form, and are thoroughly in accord with the basic principle of Americanism in initiative effort and accomplishment.
12. We are in favor of, and wholeheartedly endorse, the fourteen-point program promulgated by the Council on Medical Service and Public Relations of the American Medical Association, and will support every effort to obtain legislation; to develop ways and means; to promote dissemination; to provide cooperation; and to seek acceptance in order that the program may receive universal approval and application.

There was some question from two of the panel members as to the advisability of item Number 10. However, it was explained that all of the items were presented for the purpose of consideration and discussion, and that neither they, as individuals, nor the state organization would be bound to support these suggestions unless they become a definite part of the program of the Council on Medical Service and Public Relations of the American Medical Association. The primary intent, of course, is to bring out the value of any and all suggestions for the betterment of medical practice. The panel has unanimously approved all of the other items, and they have been forwarded to the chairman of the committee.

### MEDICAL EDUCATION AND POSTGRADUATE TRAINING

One has but to read the scholarly exposition on this subject, appearing in the August number of our JOURNAL, by Dr. W. D. Gatch, to realize the importance of this topic. This is an indictment of many of our present methods of teaching medical students, but at the same time it carries with it a thorough insight into the problems confronting the medical student today, and helpful suggestions for the reflection of those entering this career. The father of every son who anticipates entering medical school should read this article. Every practicing physician should give it consideration. Not only does it indicate the pitfalls of specialization, but it likewise enhances the value of adequate training for the general practitioner and promotes the requirements of a satisfactory plan of postgraduate education. The recommendations embodied in this article should become a part of the program of your association in considering these pertinent topics.

### SECTION ON GENERAL PRACTICE

In line with the action of the House of Delegates, at our last annual meeting, in approving the recommendation of the Committee for the Study of Lay Activity in Medical Practice, a new Section on General Practice has been formed. Pending the election of officers of this section, the following have been appointed to function:

Chairman: J. T. Oliphant, Farmersburg.
Vice-chairman: C. S. Black, Warren.
Secretary: O. E. Wilson, Elkhart.

The purpose of this section will be to provide, to the general practitioner, the many items of medical interest that he cannot acquire in a section devoted to internal medicine or the specialties alone. It is further believed that this section may promote the interest and necessity for postgraduate training for the men in general practice.

Too long has the practitioner of general medicine been overshadowed in the dazzling light of the glamorized specialist. It is high time that his true worth be recognized and that he be placed on an equal basis of identity with the specialist, through certification by a national board acknowledging his qualifications to practice general medicine. This proposition is not new, but enthusiasm for its accomplishment needs revival. Perhaps initial action by a state organization may prove effective in forcing the issue. It is not too small a matter for our House of Delegates to consider initiating such a step.

### INDIANA UNIVERSITY SCHOOL OF MEDICINE

Very few Class-A medical schools in the country are conducted on a basis of division of the curriculum between two institutions located in different cities of the state. Indiana is one of these. The disadvantages of such a situation are too obvious and too numerous to detail. The advantages of having the entire medical course located in a large center where facilities may be correlated for the practical instruction of undergraduates; for the sustained interest and education of interns and residents; for a distinct aid to establishment and qualification for specialization; and for the promulgation of postgraduate training are evident. One

can visualize the necessity for automobile manufacturers to ship parts to various centers for the assembly there of the completed car, but no one can truthfully recognize the need, nor the advisability, of giving a part of the medical course at one institution, devoid of practical application, and completing it at another, when the whole program of development is so intimately correlated.

The Executive Committee has expressed its approval of the consolidation of the School of Medicine into one unit, in Indianapolis, and a recommendation is made to the House of Delegates that they record their approval of this consolidation, and transmit it to the Governor and to the President of Indiana University and the Board of Trustees.

### ANNUAL RE-REGISTRATION FEE

A recommendation is again made to the House of Delegates that an adequate re-registration fee be established, through presentation of a bill to the legislature providing for such a measure. This amount should not be less than two dollars. The necessity for such an action must be evident. Not only would the funds supplied be of material assistance to the State Board of Registration in detecting and prosecuting irregular offenders, but would also furnish a means of rounding-up the individuals who are practicing illegally. The small cost entailed for this protection should prove a worthwhile investment.

### MISCELLANEOUS ACTIVITIES

During the year numerous suggestions have been made by committees, the approval of which, by the Executive Committee, would have entailed the expenditure of various sums of money for which no provision had been made by the Budget Committee. Many of these suggestions are of worth-while character and should be acted upon promptly. Instead, the Executive Committee is forced to approve in principle the suggestions made, but are without power to afford financial assistance toward carrying out the project indicated.

We have in our treasury a considerable surplus which lies dormant year after year, and a portion of which might well be put to work to accomplish the various objectives presented as miscellaneous activities. In addition, the present tumultuous transition existing in our national picture, regarding medical practice, leaves a helpless feeling of uncertainty in dealing with problems requiring expenditures where no funds are available.

Your Executive Committee feels this sense of inadequacy in attempting to deal with such situations. No group can hold back the irresistible currents of change and progress, nor can it influence the direction and destiny of social programs unless it recognizes its responsibilities and affords the indispensable means to influence such forces.

Therefore, it seems most expedient that a fund of $10,000 be appropriated from our surplus, for use at the discretion of the Executive Committee, for the promulgation of such projects as do not normally come under budget requirements. A full accounting of the expenditures made from this fund should be reported to the House of Delegates each year at the annual session, and the depletion of the fund, through expenditures, augmented each year from our surplus in order to return it to the $10,000 level.

### THERE'S WORK TO BE DONE!

As this report is written, the purple shadows of war are lifting all over the world, and the lights of freedom are beginning to glow and brighten. The War is over—Peace is here! The solicitous care with which we strove to carry the sparks of meaning in such words and phrases as "democracy," "preservation of our way of life," "the American way," and "the Bill of Rights" now furnish the bright illumination that dispels the darkened concern. Destiny in her workshop is moulding a new and brighter model of hope and faith for the future of humanity; a strange and unfamiliar design fashioned from the fragments of a disrupted civilization.

Gone are the rivers of blood, the horrors of mutilation, the deafening thunder of artillery fire, the staccato roar of machine guns, the high-pitched shriek of devastating bombs, the silenced annihilation of the atomic bomb—which we fervently hope will remain a supreme and secret possession, the wretchedness and hopelessness of prison and concentration camps, the yells of challenge and defiance, the screams of agony, the curses of hate, and the sickening gasps of expiring life. Victory has brought pride and gladness to the hearts of many, but it has also brought mangled youth, memories of the dead, and tears to desolate homes.

Through the years we have seen our ideals of service and faith in medicine strengthened and maintained by organized efforts toward a common goal—the conquest of disease and the lengthening of the span of life. Progress has been manifest in the best vital statistics of any nation on earth, and in the quality of medical service rendered our people—all this brought about by continuous, persistent, ambitious allegiance to the principles and practices of service to our fellow men, and the advancement of our profession. And throughout it all, we have constantly been our own severest taskmasters.

Now comes the rumbling of discordant noises in our temple. Vast sums are appropriated for government bureaus, for foundations, for self-glorifiers, for politicians, for rabble-rousers, and for job-seekers to shake down the banners of proud accomplishment and substitute the pennants of discouragement. Traditions are flaunted, methods are attacked, customs are assaulted, precedents are ignored in the subversive efforts to overthrow our faith and loyalty to the ideals that influenced us to take up and carry the standard of medicine.

That we believe our ideals are sound and worth fighting for must be shown in our willingness to

organize and cooperate for the accomplishment of the work laid out for us. No attack can dim our ambition, no intrusion on our rights can obscure our purpose, no aggression can impede our progress, and no siege can blockade our activity nor, we hope, our usefulness. Our fundamental precepts are sound and sustained in the granite of freedom and accomplishment; our faith is sublime, and will not falter in the fires of political and social invasion. We have a noble God-given profession, and we will uphold its traditions. Complacency is an attitude which none of us can afford to adopt or allow to surround us.

I want to paraphrase the statements of a great American physician, to fit our present situation:

Our success depends upon a few basic features: the complete cooperation of medicine in whatever the most doubting must now admit is a truly medical emergency; our unqualified willingness to serve however, wherever, and whenever required; and a firm purpose to establish the fact that medicine intends to maintain its place in the forefront, as it always has, when an example of service is of such great significance.

*There's work to be done!*

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# INFECTIOUS MONONUCLEOSIS

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Although infectious mononucleosis is a relatively common disease it is often overlooked, probably because of its varied clinical picture. It was first described by Filatow, in 1885,[1] and given the name glandular fever by Pfeiffer, in 1889.[2] Türk, in 1907,[3] and Burns, in 1909,[4] called attention to the abnormalities in the blood picture, but their work received little attention. In 1920, Sprunt and Evans[5] described the changes in the peripheral blood, stating that the disease was characterized by an increase in mononuclear and other abnormal cells. Prior to this many authors reported cases of leukemia with recovery, which were, in all probability, infectious mononucleosis.[6] Many excellent reviews have been written on this subject, especially that by Bernstein.[7]

Years ago this disease was thought to occur only in children, but in 1908, Terflinger[8] reported one hundred fifty cases in adults. Although over 80 per cent of the cases are seen in young adults, between fifteen and thirty, the disease may occur at any age up to seventy.[9] The incidence is higher among males than females, with a 3:2 ratio. The disease may occur in any race, and has been observed in all parts of the world. Many epidemics have been reported, most of them occurring in the spring and fall. Sporadic cases are seen throughout the year. The incubation period varies from one to thirty days, with an average of eleven days. The epidemics usually occur in institutions such as colleges, military camps, nurses' homes, and orphanages. Although the disease is not highly contagious, one would expect an increase incidence whenever young people live in close proximity.

The cause of this disease is still unknown. Nyfeldt[10] isolated an organism from the blood stream in several cases, and called it B. Monocytogenes hominis. No one has been able to confirm this work. Smears and cultures of excretion and secretion of the nasopharynx have yielded a high incidence of Vincent's organisms, but the incidence is no higher than that found in healthy persons.[11] Pons and Julianelle[12] reported finding Listerella Monocytogenes. Later work from the same laboratory led to the conclusion that this organism was not the actual incitant.[13] It was felt by some that the etiologic agent may be a virus,[14] but this, too, has been proved wrong.[15] As always, in any condition in which the causative factor has not been found, allergy is suspected. This idea recently has been set forth by Randolph and Gibson[16] because they found

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[1] Filatow, N.: *Lectures on the Acute Infectious Diseases of Children*, A. Lang, Moscow, 1885.

[2] Pfeiffer, E.: Drüsenfieber, *Jahr. f. Kinderh.*, **29**:257, 1889.

[3] Türk, W. M.: Septische êrkrankungen bei Verkümmerung des granulozytensystems, *Wien. klin. Wchnschr.*, **20**:157, 1907.

[4] Burns, J. E.: Glandular Fever—Report of an epidemic in the Children's Ward of the Union Protestant Infirmary, *Arch. Int. Med.*, **4**:118, 1909.

[5] Sprunt, T. P., and Evans, F. A.: Mononuclear Leukocytosis in Reaction to Acute Infections (Infectious Mononucleosis), *Bull. Johns Hopkins Hosp.*, **31**:410, 1920.

[6] Ireland, R. A.; Baetjer, W. A., and Ruhräh, J.: A Case of Lymphatic Leukemia with Apparent Cure, *J.A.M.A.*, **65**:948, 1915.

[7] Bernstein, A.: Infectious Mononucleosis. *Medicine*, **19**:85, 1940.

[8] Terflinger, F. W.: Epidemic of Glandular Fever, *J.A.M.A.*, **50**:765, 1908.

[9] Moir, J. I.: Glandular Fever in the Falkland Islands, *Brit. M. J.*, **2**:822, 1930.

[10] Nyfeldt, A.: Etiologie de la mononucleose infectieuse, *Compt. rend. Soc. de biol.*, **101**:590, 1929.

[11] Baldridge, C. W.; Rohner, F. J., and Hansmann, G. H.: Glandular Fever (Infectious Mononucleosis), *Arch. Int. Med.*, **38**:413, 1926.

[12] Pons, C. A., and Julianelle, L. A.: Isolation of Listerella Monocytogenes from Infectious Mononucleosis, *Proc. Exp. Biol. and Med.*, **40**:360, 1939.

[13] Julianelle, L. A.: The Function of Listerella in Infection, *Ann. Int. Med.*, **14**:608, 1940.

a large number of Downey cells in cases of allergy. This statement has been challenged by Immerman.[17] During the past twenty years no specific agent has been found in the cases seen at the University of Iowa.

The prodromal symptoms vary somewhat, and even during an epidemic the mode of onset is inconstant. Although infectious mononucleosis can simulate any acute or subacute infection, the initial symptoms can be grouped into five separate classes. In the first type the illness starts with a high fever, either septic or more or less sustained for a few days. Headache is common and prostration is marked, and nausea and vomiting may be present during the first day or two. As a rule there are no localizing signs such as are present in meningitis and anterior poliomyelitis. These patients exhibit little adenopathy at first, but later a few enlarged nodes can be palpated. The total leukocyte count is elevated, with a high percentage of polymorphonuclear cells. The second type of onset occurs with some fever, sore throat, and at times a membranous angina. The pyrexia is less marked than in the first group, as are the constitutional signs. The leukocyte count is elevated, but the polymorphonuclears may be normal. A few enlarged nodes can be felt from the onset. The third group of patients have only slight fever and a few palpable, tender nodes, but no throat symptoms. In the fourth group the disease usually begins with abdominal pain, often over the lower part of the abdomen, and mild fever and leukocytosis are present. These patients may be suspected of having acute appendicitis.[18] At first, on initial examination, no lymphadenopathy is found; however, several days later the nodes become tender and readily palpable. The last group has an insidious onset, with very mild symptoms and a few enlarged, slightly tender nodes. The blood smear shows evidence of infectious mononucleosis and the Paul-Bunnell test is positive. Medical students and student nurses usually fall into this group.

Most of the patients entering the University of Iowa hospital are students, and usually are seen early in the disease. A small number have had symptoms for days or weeks before seeking admission. The symptoms are usually headache, fever, sore throat, and tender nodes. Aside from these common complaints, many other symptoms are related, and these are outlined in Table I. During times of epidemics, such as meningitis, anterior poliomyelitis, measles, or scarlet fever, the symptoms may be misleading, and it is only after careful laboratory studies and complete physical examination that the diagnosis becomes evident. Many of our patients are admitted to the isolation service because of acute nasopharyngitis, which is similar to the experience in Army camps.[19]

TABLE I

SYMPTOMS IN ORDER OF FREQUENCY

| | |
|---|---|
| Headache | Pain in neck |
| Fever | Nervousness |
| Sore Throat | Abdominal Pain |
| Tender Glands | Pain on Moving Eyeballs |
| Constipation | Weakness |
| Chills | Vomiting |
| Malaise | Sore, bleeding gums |
| Backache | Loss of weight |
| Coryza | Cough |
| Irritability | Hoarseness |
| Fatigue | Photophobia |
| Sweats | Jaundice |
| Anorexia | Diarrhea |
| Dizziness | Arthralgia |
| Nausea | |

Fever is present in nearly all cases and parallels the symptoms of the disease. Occasionally a patient may run an afebrile course, but as a rule most of these patients have had a slight elevation of temperature before admission to the hospital. It is not uncommon for the temperature to drop to normal, only to rise again, and this is usually coincident with a delayed onset of glandular swelling. The fever is remittent in most instances, and in a few cases may persist for many weeks. The average duration of the fever is about one week. The pulse rate runs parallel to the temperature, with a tendency to be slower than in the average infection.

A few enlarged lymph nodes can be found in all cases. The distribution and degree of enlargement are variable. The nodes are discrete, only slightly tender, and appear in chains. At first only the cervical nodes may be felt, later the axillary, submaxillary, and subangular. The more carefully one searches, the more involvement can be found. Many of our patients exhibited enlargement of all the lymph nodes, including the femorals, postauricular, and submental. In chronic lymphatic leukemia the submental gland is usually involved, and we formerly thought that this may help differentiate this disease from infectious mononucleosis. Recently we have seen several patients with proved infectious mononucleosis, all of whom had enlargement of all the nodes, including the submental. Enlargement of the nodes may appear before the fever, and may be an early indication of the presence of this illness. The lymph nodes re-

[14] (a) Van der Berghe, L.; Liessan, P., and Kovacs, L.: Transmission de la mononucleose infectieuse humain (fievre ganglionaire de Pfeiffer) au Macacus rhesus et son pasage successifs d'un virus filtrant, *Compt. rend. Soc. de biol.*, **130**:279, 1939.

(b) Nettleship, A.: On Infectious Mononucleosis, *Proc. Exp. Biol. and Med.*, **49**:116, 1942.

[15] Julianelle, L. A.; Bierbaum, O. S., and Moore, C. V.: Studies on Infectious Mononucleosis, *Ann. Int. Med.*, **20**:281, 1944.

[16] Randolph, T. G., and Gibson, E. B.: Blood Studies in Allergy; Presence in Allergic Disease of Atypical Lymphocytes and Symptoms Suggesting Recovery Phase of Infectious Mononucleosis, *Am. J. M. Sc.*, **207**:638, 1944.

[17] Immerman, S. I.: An Epidemic of Infectious Mononucleosis with a Report of Two Hundred Twenty Cases, *Med. Record*, **157**:480, 1944.

[18] (a) Tidy, H. L., and Daniel, E. C.: Glandular Fever and Infectious Mononucleosis, with an account of an epidemic, *Lancet*, **2**:9, 1923.

(b) Davidsohn, I.: Infectious Mononucleosis, *Am. J. Dis. Child*, **49**:1222, 1935.

[19] Mitchell, R. H., and Zetzel, L.: Infectious Mononucleosis in the Army, *War. Med.*, **5**:356, 1944.

cede gradually, but sometimes remain enlarged for weeks or months.

Abdominal pain may be a predominant feature during certain epidemics.[20, 19] The pain may be generalized or localized, suggesting acute appendicitis or cholecystitis. We have seen a few patients, mostly males, who had a slight fever, rebound tenderness in right lower quadrant, and a moderate leukocytosis, but no superficial adenopathy. In these cases a diagnosis of acute appendicitis was made and an operation performed. The appendices were normal, but all of the patients had mild enlargement of the intra-abdominal nodes.

Enlargement of the spleen can be found in about half of the cases. The spleen may not be palpable at first, but by the end of a week it reaches its maximum size. This organ is soft and only slightly tender. The enlargement may persist for weeks or months, and occasionally for many years. In 1926, Baldridge, Hansmann, and Rohner[11] reported one young woman whose spleen remained enlarged for seven years. We were fortunate in being able to examine this same woman eighteen years after she had had the disease, and the spleen was still 6 cm. below the costal margin. It is of interest that she still had many abnormal mononuclears in the blood smear, but the total leukocyte count was normal. Nothing could be found to suggest chronic leukemia. The liver may also be enlarged, but less often than the spleen. The hepatic enlargement is never great, the edge usually being about 3 to 4 cm. below the midcostal margin. Jaundice sometimes occurs in this disease, but is not always associated with enlargement of the liver. Icterus is not seen very often, and in our series was never severe.

Involvement of the central nervous system is more common than had been suspected. Many of the patients at first may appear on cursory examination to have meningitis, acute anterior poliomyelitis, or encephalitis. Headache starts early, followed soon by pain and stiffness of the neck. The Kernig and Babinski signs may be positive in a few, but are absent in most cases. Marked irritability and lassitude occur frequently, but stupor, coma, and convulsions are rare. The opthalmoscopic examination is always negative. Unfortunately, because this disease is seen so often in medical students and nurses, lumbar puncture is not carried out.

Among the other abnormalities that may be present are, first, the skin rashes. These can simulate urticarial, erythematous, or scarlatinal eruptions. The skin lesions appear early and disappear promptly. Within the past few years, with the increase in the consumption of barbiturate derivatives, the possibility of a drug eruption must always be kept in mind. We have never seen a true endocarditis resulting from infectious mononucleosis. An apical systolic murmur may be heard during the febrile period, but this usually disappears when the temperature becomes normal. Sore throat is usually thought to be a part of the disease. This was present in about sixty per cent of our cases, and varied from redness of the nasopharynx to a membranous pharyngitis. Pharyngeal manifestations are probably secondary in nature, and, as Bernstein[7] suggests, merely a complication of the disease. (Table II.)

**TABLE II**

**PHYSICAL FINDINGS IN ORDER OF FREQUENCY**

| | |
|---|---|
| Fever | Enlarged Tonsils |
| Enlarged Glands | Membranous Angina |
| Posterior-Cervicals | Enlarged Spleen |
| Submaxillary | Puffiness of Eyelids |
| Subangular | Abdominal Tenderness |
| Axillary | Enlarged Liver |
| Epitrochlear | Stiffness of Neck |
| Inguinal | Peritonsillar Abscess |
| Femoral | Jaundice |
| Submental | Rash |
| Tender Glands | Herpes Labialis |
| Throat Injected | Enlarged Thyroid |

The most consistent laboratory findings are the blood studies. The earliest change is a moderate leukocytosis, with a relative increase in polymorphonuclears. The total leukocyte count may vary from normal to 20,000 cells per cm., but occasionally the count may go as high as 50,000. The leukocytosis is present during the febrile period. After a few days the total leukocyte count ordinarily returns to normal. The myeloid cells decrease in number, and the so-called "mononuclear cells" either make their initial appearance or increase rapidly to reach a peak during the first and second week. Later the mononucleosis diminishes slowly over a period of weeks or months. Whether the mononuclear cell is of lymphoid or reticulo-endothelial origin is not germane to the discussion. Because the mononuclear cell is typical of this disease, a more complete description of its appearance, when stained with Wright's stain, is in order. The size of these cells varies from that of a small lymphocyte to several times the diameter of a polymorphonuclear. The nucleus is wavy and irregular, and is much the same as that of a normal lymphocyte. It is usually placed eccentrically and has a horseshoe or irregularly-lobulated shape. The cytoplasm in the most typical cell is abundant, and stains slightly basophilic at the periphery. The rest of the cytoplasm is hyaline, and may contain a few large granules. A few cells can be found in which the cytoplasm is stained a deep blue and contains a few vacuoles.

The hemoglobin and erythrocytes are normal unless a complication is present. The platelet count, prothrombin time, and clotting time are within normal limits. The blood urea nitrogen, blood creatinine, blood calcium, blood phosphorus, and blood proteins are normal. The blood Wassermann reaction becomes positive in about 5 per cent of the cases early in the disease. By the end of the third

[20] West, J. P.: An Epidemic of Glandular Fever, *Arch. Pediat.*, **13**:889, 1896.

week the Wassermann reaction reverts to negative, thus ruling out syphilis as the cause of the illness.

Transient albuminuria often occurs when there is considerable fever. A few hyaline and granular casts may be found during the time of the albuminuria. Erythrocytes have not been found in the urine in any of our cases. Blood cultures have failed to reveal any organism. The cerebrospinal fluid in this disease shows definite changes. The pressure is moderately elevated, and the fluid is clear and colorless. A pleocytosis ranging from 50 to 1,000 cells may be found, and the cells are typical mononuclears. The protein content is increased and the sugar content is normal. Cultures of the cerebrospinal fluid are always sterile. The Wassermann reaction is negative, even though the blood Wassermann is positive. In 1932, Paul and Bunnell[21] studied sera from cases of rheumatic fever and hospital patients suffering from other diseases. The serum of one patient with infectious mononucleosis showed a high titer of sheep-cell agglutinins. Since then it has been found that the majority of patients with infectious mononucleosis have sheep-cell agglutinins in their serum in a titer of at least 1:160. This test becomes positive about four or five days after the onset of the illness, and the titer increases, reaching a peak by the fourth week. The antibody then slowly diminishes and returns to normal levels between the fourth and the fifth month. This test is rarely positive in other diseases, but unfortunately is negative in at least 10 per cent or more of the cases of proved infectious mononucleosis.

The benign nature of this disease has limited the histologic observation to a few nodes. Deaths have been rare, but recently Ziegler[22] reported observations on a young woman who died after rupture of the spleen. He stated that the lesions are focal in character, and exhibit mononuclear infiltration, reticulocyte proliferation, and necrosis. These changes were found in the lymph nodes, liver, kidneys, spleen, and lungs, and were suggestive of an infectious granuloma. Two other instances of rupture of the spleen have been reported, but both of these patients recovered after surgical intervention.[23]

The differential diagnosis is difficult at first because the onset is similar to that of many other diseases. Usually, this superficial similarity becomes less striking after a few days, when the blood smear shows the abnormal mononuclear cells, or when the Paul-Bunnell test becomes positive. When the disease is ushered in with a septic type of temperature it must be differentiated from septicemia, typhoid fever, brucellosis, atypical primary pneumonia, acute rheumatic fever, miliary tuberculosis, dengue and dengue-like fever, anterior poliomyelitis, and encephalitis. When the fever is associated with sore throat, one must suspect diphtheria, Vincent's angina, follicular tonsillitis, or scarlet fever. If the fever is mild, mumps or German measles must be considered. The difficulty of differentiating infectious mononucleosis from appendicitis has already been mentioned. The enlarged lymph nodes makes one consider the leukemias, Hodgkin's disease, tuberculosis, syphilis, and granuloma inguinale. The presence of jaundice, particularly during epidemics, makes the differentiation from acute infectious hepatitis difficult. Here one must rely on a positive Paul-Bunnell test, the differential blood count, the normal blood proteins, and normal liver-function tests. Disseminated lupus erythematosus may also be confused with this disease, but the laboratory data and absence of lupus-like lesions on the face and fingertips make the diagnosis definite.

The treatment of this condition is symptomatic. Although the contagiousness is questionable, we believe in isolating the patient. No specific therapy has been found. The sulfonamide drugs have been advocated,[24] but we have found them to be of little or no value. Penicillin is of too recent origin to draw any conclusions, but apparently this drug, too, seems to have little effect on the cause of the disease. It is necessary to keep the patients at rest in bed, particularly after the temperature returns to normal, for relapses are very common. Zetzel recommends the use of graduated physical exercises to shorten the period of convalescence.[19]

**TABLE III**

A Paul-Bunnell test should be performed in the following cases:

I. Individuals with unexplained lymphocytosis or glandular enlargement.
II. Individuals with positive agglutination tests (Widal, etc.) without cultural confirmation.
III. Individuals with false positive Wassermann reactions.
IV. Individuals with unexplained acute abdominal conditions.
V. Individuals with enlarged spleen of unexplained cause.
VI. Patients with atypical forms of conjunctivitis or puffy eyelids.
VII. Apparent cases of (a) infectious hepatitis, (b) Vincent's infections, (c) aphthous stomatitis, (d) benign lymphocytic meningitis, and (e) agranulocytosis.

Berstein[7] has made a plea for wider use of the Paul-Bunnell test on patients with fever of unknown origin and other symptoms as shown in Table III. The clinical picture, although extremely varied, can be distinguished by careful observation, differential blood counts, and the Paul-Bunnell test. The disease is generally self-limited; the prognosis is favorable, and mortalities are extremely rare.

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[21] Paul, J. R., and Bunnell, W. W.: The Presence of Heterophile Antibodies in Infectious Mononucleosis, *Am. J. M. Sc.*, **183**:90, 1932.

[22] Ziegler, E. E.: Infectious Mononucleosis—Report of a Fatal Case with Autopsy, *Arch. Path.*, **37**:196, 1944.

[23] (a) Friesleben, M.: Ein durch Splenektomie geheilter seltner fall von Spontanruptur der milz, *Deutsche Ztschr. f. Chir.*, **173**:45, 1922.

(b) King, R. B.: Spontaneous Rupture of the Spleen in Infectious Mononucleosis—Report of a Case, *New England J. Med.*, **224**:1058, 1941.

[24] Hoffman, H. J.; Lees, H. D., and Comroe, B. I.: Use of Sulfathiazole in Infectious Mononucleosis, *Am. J. M. Sc.*, **203**:731, 1942.

# UPPER RESPIRATORY INFECTIONS IN CHILDREN WITH SPECIAL REFERENCE TO INVOLVEMENT OF LYMPHOID TISSUE*

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ELKHART

In discussing children, we will consider an anatomy and physiology quite different from those of the adult. The infant is born with certain lymphoid placements that his grandfather no longer has. As he grows older these lymphoid masses become larger, but not in proportion to the total gain in body weight. That these bodies of tissue must play some important role in the physiology of the child is evidenced by the universal presence thereof in the throat of all immature human beings. The child certainly is not an adult in miniature, yet often during private and school round-up examinations where large tonsils are seen, the examiner exclaims, "Them big tonsils gotta come out!"—all this without regard to the possible absence of other deficiencies in the physiology of the organism.

Indications for the removal of tonsils and adenoid tissue are at great variance in the mind of various authors. Textbooks, even late publications, are a very clouded if not tricky guide in directing such decisions. Often a picture of a child with "adenoid facies" is included. Quotations include: "Enlarged adenoid tissue frequently causes nasal obstruction with mouth-breathing and nasal discharge." "Hypertrophy of the tonsils is common between the ages of four and sixteen." "Hypertrophy is sometimes present in infants and may even be congenital." "Transillumination of the tonsils show from normal to slightly diseased conditions or fully infected tonsils by the presence of a warm amber, bright amber, and red or rose amber color." However, even if not color-blind, the average physician would find that matching shades is most undependable.

From a fanciful and practical view, we must consider lymphoid tissue common, if not inevitable, in the upper respiratory tract of the child. Here it forms the background of all pictures of infection in this area, if not the primary—at least becoming involved as the secondary and more conspicuous area of the nose and throat zone. Lymphoid tissue is found in patches and in aggregations in the upper throat, down through the pharynx and larynx, and connecting with the nodes of the bronchial tree system. Lymphoid tissue plays an important and undisputed role as a natural barrier to extension of bacterial infections, and may, in this function, become infected and serve as a secondary focus of infection. Infections in any part of this system may easily involve those follicles connected with it, especially those proximal to the initial lesion.

Tonsils and adenoids have two characteristics that differentiate them from other lymphoid tissue: the presence of crypts from which desquamated epithelium, pus cells, and bacterial flora are extruded to the surface, and lymph vessels that leave, but none that enter these structures. In my experience I have found a high degree of uniformity in the relative size of the tonsil and the adenoid tissue in the same person. Large tonsil, large adenoid; small tonsil, small adenoid has been most regularly verified with nasopharyngoscopy. Lymphoid tissue is by no means limited to these larger groups. Like Peyer's patches, there are follicles scattered throughout the submucosa of the pharynx, the nasopharynx, and even bits of this tissue in the orifice of the eustachian tubes. One author states that infections involving the eustachian tubes may result in the finding of lymphoid tissue in the middle ear. Without infection, this does not occur even in the eustachian tube. He does not explain how lymphoid tissue may conveniently spread itself to accommodate infections. The author has no proof that lymphoid tissue did not exist before the infection, so let us believe that involvement of this previously-existing tissue states the sequence without assumption.

Infections involving the throat may mean tonsillitis or pharyngitis. Sore throat does not necessarily mean tonsillitis, and removal of tonsils to interrupt attacks of sore throat eventually may leave the surgeon embarrassed. Tonsillitis is not present without redness and swelling of the lymph follicles of the pharynx, so the diagnosis of tonsillitis is rather critical and requires inspection by a physician. Inspection by the mother is not sufficient.

More than twenty years ago a controversy raged over the actual existence of chronic appendicitis as an entity. It is now generally agreed that acute attacks of appendicitis may recur, but that chronic inflammation of the appendix does not exist. This causes one to wonder if, in like manner, chronic tonsillitis really exists. Acute infections of the tonsil and other lymphoid tissues in the throats of children are common. Such infections are especially common in the region of the Great Lakes, along the seaboards, and where the climate is generally different from the cool and dry. Hyperplastic changes in the tonsillar tissues produced by recurrent acute attacks may be confused with the term "chronic." The general health of the child usually determines the frequency and the recurrence of attacks of upper respiratory infections.

Whatever the size of the adenoid tissue, I have never seen nasal obstruction with resultant mouth-breathing due to enlargement of this structure. Sinusitis or nasal allergy, or both, have been the

* Read before the St. Joseph County Medical Society, at South Bend, on October 10, 1944.

causative factors, in my experience, in acquired obstructed nasal passages. All too often the assumed indication for removal of tonsils and adenoids is to relieve nasal obstruction. Mouth-breathing continues after the surgical removal, and a spurious diagnosis of a mouth-breathing habit is glibly spewed in self-defense.

Unger states that "it behooves the medical profession to re-examine the evidence in its possession on the role the tonsil plays as a disease-dispersing factor, and to re-appraise the value of tonsillectomy with the purpose of confirming it as the procedure of choice, of modifying it, or of discarding it, as may best serve the needs of the patient."

Emenhiser believes that yellowish secretion in the tonsillar crypts or the consistency of the tonsil is no guide. The author states that a questionnaire brought many replies from clinicians and pediatricians concerning the value of tonsillectomy in those conditions where focal infection might play a part. Almost without exception, the replies considered the results of tonsillectomy to be of doubtful or of no benefit, either prophylactically or therapeutically. He believes that they should be removed when so large as to interfere with breathing, or when the tonsils harbor infection.

Coates decries injudicious tonsillectomies. He says, "Tonsillectomy should be performed only when indications warrant it, based on the cooperative judgment of the otologist and the internist, and then only will the desired result be effected." It might well be stated that the poor health of the child may be the cause of the tonsillitis, and is not always the result thereof.

Kaiser reviewed 4,400 children over a ten-year period, half of whom had their tonsils and adenoid tissue removed. The average frequency of colds in each group was the same, but there were more pulmonary infections in the operated group. Nasal sinusitis and allergy were not favorably affected by removal. Erwin Schiff believes this operation is performed all too frequently. Recurrent tonsillitis, peritonsillar abscess, and persistent enlargement of the tonsils are his suggested indications for their removal. In cases of suspected focal infections he warns that this procedure results almost universally in failure. Ridges, however, defines adenoid tissue as pathological enlargement of the pharyngeal tonsil, and says it should be removed. His definition is certainly orginal. Schenck asserts that lymphoid tissue in the nasopharynx, Waldeyer's ring, is susceptible to the same infections as lymphoid follicles elsewhere, and the sinuses play an important part in the reinfection of this tissue.

Barbosa calls attention to the frequency of nasal obstruction in infants due to sinus disease. So often diagnosed in the chronic state, an earlier and thorough examination would have revealed the true condition when conservative measures would have been effective. Wishart finds sinus disease occurring in 30 per cent of children, and stresses the importance of preventing chronic sinusitis by early treatment.

If sincere appreciation of all circumstances, in your opinion, warrants the removal of the tonsils and adenoid tissue, then remove them, but hold the reservation that more may need to be done. Removing these aggregations results in the compensatory hypertrophy of the remaining follicles. Many of the cases included in this report show continued or aggravated symptoms following the removal of the tonsils and adenoid tissue.

Allergic swelling of the nasal mucous membrane often blocks the sinus openings, interferes with sinus ventilation, and thus provides the necessary condition for sinus infections. Such a mixed picture requires that the sinus disease be treated simultaneously with or before that of allergy. Acute infections in the nose and throat may be treated with the sulfonamides, both prophylactically and therapeutically, with generally excellent results. Crowe emphasizes the importance of irradiation of hyperplastic lymphoid tissue in children who have undergone adenoidectomy and still show impaired hearing, which includes more than half of those operated upon and improved. He said, "It is our opinion that regeneration of lymphoid tissue occurs less often under treatment by irradiation than by surgical removal of the adenoid tissue." In our series most children with a history of recurrent attacks of otitis media have had no attacks since treatments were started. Irradiation is a very useful method for reducing hyperplastic lymphoid tissue. By improving the hearing and reducing the frequency of head colds, it has definitely been our experience that school attendance is increased and that results promise more permanency, all without the bother of parental resistance to surgery.

In our cases irradiation was done through the medium of x-ray. The physiological effect is an immediate hyperemia of the lymph follicles, followed in several days by a decrease in the number of lymph cells. Late results are the replacement of lymphocytes by fibrous tissue. The rationale of such treatment which destroys certain tissues might well be questioned as to the future result from this transformation. For instance, surgical removal of tonsillar tissue has not only gone unquestioned, but has fallen short of its former promises in many cases. Irradiation has been generally accepted for minor skin lesions. In the throat cases the dose is controlled both as to output and localization, and the results have been sufficiently good to earn a place in the treatment of recurrent upper respiratory infections with enlarged lymph follicles. Surgery, too often a palliative, has ventured far more than is suggested here.

*Case 1.* V. G., aged ten, was seen August 27, 1942, with acute pharyngitis, displaying large, red, elevated lymphoid nodules in chains along the sides of the pharynx, extending into the nasopharynx. She had a history of continuous head colds throughout each winter, with frequent tonsilitis. Besides local and sulfa drug therapy, x-ray was carried out

in deep therapy style. Two years later, August 31, 1944, the pharynx showed few non-elevated nodules, tonsils were pink and not enlarged, and she gave a history of only a single attack of tonsilitis and three attacks of coryza, of brief duration, during the past winter.

*Case 2.* L. H., aged five, gave a history of a mild attack of acute rheumatic fever, continuous head colds each winter, and showed on examination that both tonsils were small but red, and pharyngeal lymphoid patches which were red and very prominent. Nasal cavities were negative for redness, swelling, or evidence of secretion. X-ray treatments were given in July, 1943, and inspection and history on August 25, 1944, showed that the tonsils were pink, pharynx was smooth, and that there had been only a single attack of mild coryza the previous May.

*Case 3.* N. L., aged four, on April 5, 1943, showed a marked swelling of the lymphoid chain on the right side of the pharynx, cervical adenitis, pink tonsils, and a moderately high fever. Sulfathiazole, gr. 7½ every four hours, caused disappearance of the pharyngitis in thirty-six hours, with cervical nodes smaller and no longer tender. On December 2, 1943, a severe cough developed for one week, with a very red, granular pharynx. Deep therapy x-ray stopped the cough on the second day, and no further infections of the upper respiratory tract occurred except one brief and minor head cold contracted August 1, 1944.

*Case 4.* V. B., aged ten, who complained of impairment of hearing in the right ear, had adenoid tissue removed a year previously without benefit. On July 19, 1943, both drums were retracted, the right very markedly, with negative Rinne, swollen lymphoid tissue in nasopharynx, and edema of the openings of both eustachian tubes. X-ray treatments were started, and on March 2, 1944, eight months later, the hearing had definitely improved, but retraction of both drums still persisted. On August 25, 1944, there was no retraction of either drum, but the hearing was still limited to whispered voice on contact in the right ear, even after air inflation. This case shows that relief of the tubal obstruction must be accomplished early to prevent permanent impairment of hearing.

*Case 7.* J. H., aged eight, seen August 23, 1940, with history of impaired hearing, frequent colds, retracted drums, and red, raised granules in the lateral walls of the pharynx and nasopharynx. X-ray treatments were given, and six months later the pharynx was smooth, retraction was gone, and hearing was normal. No head colds reported up to August, 1944.

*Case 10.* E. S., aged nine, seen April 21, 1942, referred by school nurse for impaired hearing in right ear. He had a red, granular pharynx, large, red tonsils, and a history of frequent colds. X-ray treatments were carried out in June, 1942. In September, 1944, examination disclosed a smooth pharynx, no retraction of either drum, tonsils were smaller and pink, and the hearing was normal.

*Case 11.* I. S., aged thirteen, seen on November 7, 1942, had frequent colds and sore throat. Tonsils were red, large, and mostly buried; pharyngeal tistue was enlarged and red. X-ray treatments were given. The mother's reply to our questionnaire was, "It is a pleasure for me to write to you in regard to I's throat. Before she had the x-ray treatment she was sick with a sore throat winter and summer. Since the x-ray she has had only one minor cold, and we never spent money for anything that has done as much good."

*Case 13.* D. B., aged eight, was seen on May 28, 1941. His tonsils were found to have been cleanly removed, yet impaired hearing had not improved. Retraction of both drums and red, granular nasopharynx seemed to indicate x-ray therapy, which was carried out. On September 17, 1944, the school nurse reported satisfactory restoration of hearing, and the mother wrote, "Much better results and greater satisfaction than from tonsillectomy."

*Case 21.* S. C., aged eleven, was seen on May 24, 1940, with impairment of hearing of three years' duration, and frequent attacks of earache. Tonsils had been removed, and mucopus was present in nasopharynx, with a red, granular pharynx, and marked retraction of both drums. Failing to respond to nose drops, the patient was referred for x-ray treatments, in July, 1940. He was last seen on March 4, 1944. Reports from his mother indicate that hearing has been uniformly good since x-ray therapy was administered, and that colds are mild and infrequent.

*Case 31.* C. B., aged eight, was picked up by a school nurse because of impaired hearing, in February, 1942, showing greatly enlarged tonsils and prominent follicles in pharyngeal lymph chains. Tonsils were removed in May, 1942, and x-ray treatments were given in October of the same year because of continued impairment of hearing. Examination on October 7, 1944, revealed a clear throat and normal hearing, and the patient's mother is highly pleased.

Since these patients are brought in by the parents, it seems logical to base our results upon their reports. While this may not even hint at scientific precision, the real proof of variations from the normal and restorations to that normal is determined by the reactions of the individual in his usual environment. Ultrascientific procedures may be not only useless but misleading and impractical in the measure of therapeutic success.

May we be constantly reminded that we are treating—not a malady, but a patient with a malady. We are not against anything except false suppositions. An idea that is accepted is not necessarily proved, and an open mind and thoughtful observation will alone hold the art of the practice of medicine above legend, superstition, and ignorance. As Dr. Arthur Proetz has so ably put it, "To my mind, the first desideratum in any treatment is ultimate, and, if possible, permanent improvement; improvement in function, first and last. The surgical fash-

ion, whether it be of the moment or a relic of the past is of no importance."


SUMMARY

For the past four decades we have had at hand a new method of treatment which, however, was not brought into use until about twelve years ago. It is only in the last five years that the value of irradiation in the treatment of lymphoid hypertrophy involving the upper respiratory tract has become more generally known and practiced—all this, in spite of the fact that thymus, bronchial lymphatics, and lymph adenopathy have been treated by x-ray for a considerable length of time.

The purpose of this paper is intended to bring to mind not so much the shortcomings of tonsil and adenoid removal in the cure or alleviation of upper respiratory ailments, but rather to promote a broader view on the basis of the patient and his malady being an entity which often requires surgical removal of the tonsils and adenoids, as well as radiation therapy to attain the functional restoration of the upper respiratory tract to normal.

Conclusions:

1. Infections in the upper respiratory tract in children often result from general poor health, and removal of tonsils alone may not benefit the patient.
2. Not all sore throats are due to tonsillitis—many are due to pharyngitis.
3. Tonsillectomy is done too frequently, and should not be performed merely because it is the suspected focus of infections.
4. Tonsillectomy is advisable only in cases with definite recurrent tonsillitis, peritonsillar abscess, or persistent enlargement out of proportion to that normally found consistent with the age of the patient.
5. Nasal obstruction may be due to sinus disease or allergy rather than enlarged adenoids.
6. Irradiation to the nasopharynx has given an exceedingly high percentage of good results in the cases that I have been able to follow, and some of these cases have been presented here.
7. Irradiation in my experience has been of value in deafness from blockage of eustachian tubes by lymphoid tissue; and in recurrent infections of lymphoid tissue in pharynx and nasopharynx, especially when removal of tonsils and adenoids had failed to give desired results.
8. Irradiation is more permanent than surgery in preventing regeneration of lymphoid tissue and in restoring normal function of the lymphoid structures in the throat.



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# PREVENTION OF DISABILITY IN TRAUMATIC CONDITIONS OF THE EXTREMITIES*


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In the surgery of trauma far more attention is usually given to the immediate treatment of injury or infection than to follow-up care, although the end result of treatment depends as much, if not more, on follow-up care as on the immediate treatment. This tendency is true not only in our teaching and textbooks and in the literature, but also in practice. The aim of treatment in the surgery of trauma is to restore the injured part as nearly as possible to its former anatomical condition, with the minimal loss of function. Anatomical restoration and healing entail inactivity, either through the employment of immobilization in treatment or because the pain and swelling associated with injury promote disuse. A certain degree of atrophy, contracture, or ankylosis necessarily ensues. Immobilization of a part, while essential for healing of an injury, is detrimental to its ultimate function. The most important aspect of rehabilitation is the prevention of unnecessary or excessive loss of function. In the present state of knowledge and with all modern facilities for physical therapy, it is still apparent that prevention of functional loss is a more fruitful field of endeavor than correction of existing disability. This has been emphasized by one of our outstanding physical therapists, Dr. John Coulter, who reiterates the plea to surgeons that "physical therapy should begin at the bedside." Physical therapists also recognize the fact that the disabilities they have to treat follow patterns which are more or less characteristic of the preceding injury. By studying these patterns surgeons can take measures to minimize the disability resulting from a given injury. The well-known dicta, "splinting in the position of function" and "early active motion" are only two of the means by which prevention of excessive disability can be achieved by surgeons treating trauma.

It is my purpose to discuss some of the common problems encountered in our Rehabilitation Clinic at St. Luke's Hospital. Many of the patients under treatment there have been previously discharged

* Presented before the LaPorte County Medical Society on May 17, 1945.

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from treatment elsewhere, with the existing disability considered as an end-result, or inevitable, and yet with careful and sometimes prolonged treatment much has been gained in restoration of function. Some patients are referred from places where adequate facilities for this type of treatment are not obtainable. Others have obstinate disabilities definitely inherent in the original injury or arising from failure to appreciate and apply fundamental principles of prevention. Still others have impairment of function in parts more or less remote from the original site of injury, where the development of disability has not been suspected. Only the ordinary problems of functional impairment encountered in the extremities, which can be minimized or prevented by the surgeon, are under consideration here.

#### Impairment of Function in the Hand

The most important function of the hand is the grip or ability to close the tips of the fingers into the palm and appose the thumb tightly against the other fingers. While ankylosis, deformity, or loss of tendon substance sometimes cannot be prevented or remedied following severe hand injuries or infections, in most instances much can be done to minimize the contracture of periarticular tissues and the formation of adhesions about joints and tendons. The tendency toward contracture of joint capsules and periarticular tissues increases with age and with the development of arthritic changes in the small joints of the hand. Particular care should be given to the prevention of contracture about these joints, especially in older patients, and in those having arthritic changes. Too often a patient who sustains an injury to only one or two fingers acquires contracture and fixation, not only of the injured digits, but of the uninjured fingers as well, because of immobilization or disuse of the entire hand. To prevent this unfortunate result, all unnecessary immobilization must be eliminated and disuse guarded against. Essential immobilization must be employed, but only in the position of function.

During the period of treatment of the acute injury, when the injured finger must be kept at rest, measures should be taken to maintain function in the adjoining fingers. At the time dressings are done the parts that can be moved with safety should be moved actively or passively, and the patient should be instructed to carry out these motions several times daily. Attention must be given to the maintenance of motion at each of the digital joints, since all are concerned in grip. Passive, and particularly active motion, should be started on an injured part as early and as far as possible without jeopardizing healing. Too much reliance is placed upon the application of heat to an injured part for the prevention or treatment of impaired function, and the use of diathermy or the infra-red lamp is often considered to be the most important aspect of rehabilitation therapy. These modalities are of secondary value to the intelligent employment of motion.

Normal flexion at a joint depends upon the existence of plications or slack at the extensor aspect of the joint capsule and periarticular tissue in the position of extension, and normal extension depends similarly on folds at the opposite aspect of the joint. Inflammation about joints produces exudates, which organize to form adhesions between these plications while the joints are immobile. Fibrous adhesions binding together the plicae or minute folds in the periarticular tissues prevent the separation and flattening out of the folds, and thereby limit motion at the involved joints. The application of heat helps to allay inflammation and the formation of exudate, and aids in the absorption of exudate, but motion is essential to prevent the formation of rigid adhesions. Once adhesions have formed, the efforts of the physical therapist must be directed toward the gradual stretching out of the adhesions, a process which usually requires months of intensive treatment, and the outcome of which depends upon the duration and density of the adhesions. Prevention of the formation of rigid adhesions makes the task of the physical therapist easier and more productive, and reduces both the amount and duration of disability in the part involved. The primary aim of treatment of the injured hand should be to restore or maintain the ability to grip the fingertips against the palm, and the thumb against the fingers.

#### Impairment of Function at the Elbow

The tendency for serious impairment of function to occur following relatively minor injuries is perhaps nowhere more apparent than at the elbow joint. Contracture, ankylosis, and myositis ossificans are notoriously prone to develop at the elbow after trauma. The immediate treatment of injuries about the elbow joint is chiefly concerned with anatomical restoration or the prevention of infection, and is not under consideration here. Following anatomical restoration and immobilization, the important feature of treatment is prevention of limitation of motion. Early mobilization of the elbow joint has frequently been stressed, and the principle of minimal immobilization of this joint is familiar. The detrimental effects of passive stretching and forcible manipulation, however, are often disregarded. It is widely recognized that forcible manipulation usually produces a decrease rather than an increase in the range of motion at the elbow joint following trauma, but confusion exists with respect to the difference between forcible manipulation and passive stretching, on the one hand, and active motion against resistance on the other. The most beneficial form of motion for the recovery of function at the elbow is active motion against increasing, graded resistance. Technicians and nurses to whom physical therapy is usually delegated often use force in the treatment of elbow limitation unless they are definitely instructed to avoid it. A device commonly used to regain exten-

sion at the elbow is the method of having the patient carry a pail filled with increasing weights of water or sand. This is widely considered to be active motion against resistance; whereas it is, in effect, passive stretching. Active motion implies the use of extensor muscles, actively, to produce extension, and of flexor muscles to produce flexion. In other words, the patient should be given exercises that employ his own muscles in providing the force against resistance. When a patient carries a weight to increase extension at the elbow, the extensor muscles are not active, but instead the flexors immediately go into protective spasm to oppose the force. Active extension exercises for the elbow should consist of the pushing against a resistance by the extensor muscles, and active flexion exercises should consist of the pulling up of weights by the flexors. Active motion carried out in this manner is not likely to be forcible enough to do harm, and at the same time it will increase the strength of the muscles by use in overcoming resistance at the joint. The use of any form of passive stretching at the elbow is fraught with danger and is to be condemned.

#### Impairment of Function at the Shoulder

The most common disability occurring at the shoulder joint is the loss of complete abduction. Although other movements at this joint may also be partially impaired following disuse, limitation of abduction constitutes the greatest handicap to the patient. Loss of abduction at the shoulder follows not only injuries in the vicinity of the joint itself, but also injuries and infections of the fingers or hand where the hand and arm are weighted down with heavy splints or wet dressings in the position of adduction. Periarthritic conditions at the shoulder, such as subdeltoid and subacromial bursitis are very prone to develop spontaneously in adults, but are particularly common after a period of disuse of the arm. Abduction becomes painful and is avoided by the patient. This leads to fixation at the joint, atrophy of the abductor muscles, and contracture of the adductors. The triad of fixation, abductor atrophy, and adductor shortening causing limitation of abduction is extremely difficult to correct by exercises, because active abduction must be carried out against a double opposing force, namely, the force of gravity on the arm plus the disadvantage of action on the abducted arm, which acts as a lever. In most instances of trauma to the upper extremity the triad is avoidable, and the development of fixation represents a poor result in the treatment of the original trauma.

Limitation of abduction at the shoulder requires a protracted period of strenuous and painful treatment for its correction, and often cannot be fully overcome. The development of rigidity at the shoulder can easily be avoided by attention to the shoulder joint in the treatment of all traumas to the upper extremity. The arm may either be immobilized in the position of abduction, or, if immobilization is not necessary, the patient should be instructed not to keep the arm against the side of the body. If the patient is confined to bed, the arm is kept away from the side with pillows or an abduction splint. The ambulatory patient is instructed to let the arm rest in an abducted position on the arm of a chair or on a table when he sits. While passive stretching at the elbow is to be condemned, it at times can be applied to the rigid shoulder with benefit, as an adjunct to the use of heat, massage, and active motion. In some cases of marked rigidity at the shoulder, passive stretching or manipulation under anesthesia is essential to recovery of abduction.

#### Impairment of Function in the Foot and Ankle

In contrast to the primary function of performance of movements in the upper extremity, the functions of weight-bearing and locomotion are of more importance in the lower extremity than a full range of joint motion. While a full range of motion at all joints is desirable, a patient can compensate for a certain amount of loss of movement at a joint in the lower limb if the position of the part is such that the weight-bearing function is not impaired. An unfortunate result not uncommonly encountered following trauma to the lower extremity is the rigid, plantar-flexed great toe, the so-called "hallux rigidus." In some instances of hallux rigidus amputation of the great toe has been necessary to restore painless weight-bearing on the foot. This complication of trauma is inexcusable and can be avoided by measures to prevent the weight of the bedclothes from resting on the toes. The great toe should always be splinted in its position of function, in the plane of the sole of the foot, and leg casts should extend beyond the distal end of the toe to hold the toe in this plane.

Rigid, plantar flexion of the ankle joint is a similar but more serious disability, and is encountered more frequently. This condition prevents the patient from getting the heel down on the floor in walking. It is extremely difficult to overcome long-standing plantar flexion of the foot and ankle. In the application of casts to the leg and ankle, the surgeon should maintain the position of the foot at 90 degrees with reference to the frontal plane of the leg. A small range of motion at the ankle will then provide not only good weight-bearing, but also fair locomotion.

Displacement of the weight-bearing line at the ankle in the sagittal plane not infrequently follows the treatment of various types of Pott's fracture. This extremely disabling complication results from unrecognized rupture of the distal tibio-fibular ligaments and interosseous membrane, with widening of the ankle mortise, and displacement of the astragalus, laterally. The ankle assumes a valgus deformity on weight-bearing, followed by persistent pain and swelling. A varus position at the ankle following immobilization can easily be corrected and is not disabling, whereas a valgus position means disability. Widening of the ankle mortise

and astragalar displacement should be ruled out in every fracture near the ankle joint and corrected at the time of reduction, if present. Pott's original criteria for successful treatment, that the weight-bearing axis and the ankle mortise be restored, are still sound.

**Impairment of Function Following Knee Injury**

A surprising number of patients who develop quadriceps atrophy with resulting weakness and instability of the knee joint after minor traumas are advised that they have a torn internal semilunar cartilage, or other internal derangement of the knee. A striking degree of quadriceps atrophy can occur in a few weeks after relatively minor knee injury. The primary cause of the atrophy is disuse, and as the patient favors the injured member and avoids quadriceps activity in walking, the muscle becomes progressively flabbier and weakened, and the knee more unstable. The instability of the knee then gives rise to repeated trauma, and a vicious circle is set up. The same factors are often responsible for poor results following surgery for internal derangements of the knee, and for the prolonged and recurrent attacks of synovitis and arthritis that occur at the joint. Prolonged immobilization of an injured knee is to be avoided, and exercises for the quadriceps muscle should be prescribed routinely and as early as possible. We have treated a large number of patients, who have been advised to undergo operation on the knee joint, simply by the use of heat, massage, and quadriceps exercises, with gradual and complete recovery. Operation on the knee in such cases, with its resulting period of disuse, aggravates the quadriceps weakness and makes the condition worse. When quadriceps atrophy occurs, not only is weight-bearing at the knee faulty and attended with further trauma, but normal locomotion is impaired.

The principles herein briefly discussed are applicable in the treatment of many other traumatic conditions. If prevention rather than correction of disability is to be achieved in the surgery of trauma, the surgeon must make rehabilitation and physical therapy his immediate concern in treatment, instead of postponing restoration of function to a later period.

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# MODERN ANESTHESIA

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Present-day anesthesia is a far cry from the analgesic etherization as demonstrated by Dr. Morton a century ago. This was during the period of discovery wherein ether, chloroform and nitrous oxide were introduced as agents for the relief of pain in surgical procedures. With this epoch-making discovery vast opportunities were opened up in the realm of surgery. However, all attention was focused on the development of surgical techniques, and anesthesia was merely regarded as a means to an end.

Soon there was a beginning realization of the need for better anesthesia. As a result, new drugs and appliances were introduced. A few lectures were inaugurated in some medical schools. Commercial houses instituted training courses in the technique of administration. This produced an era of anesthesia technicians.

Following World War I, orthopedic surgery, plastic surgery, thoracic surgery, and brain surgery came forward in rapid strides. Thus, there was created a need for something more than just relief of pain and relaxation of muscles. A beginning appreciation of the influence of anesthetics on postoperative morbidity and mortality awakened an interest in anesthesia. The co-operation and endeavors of the physiologist, the anatomist, the pharmacologist, the chemist, the anesthetist, and the surgeon lead to research activities and developments which have brought us to our present-day conception of anesthesiology.

Most discussions on anesthetic agents tend to focus attention upon the safety of some particular agent. It is true that safety should be our greatest concern, but far too little attention has been given to the skill, training, and experience of the anesthetist.

Of all the inhalation agents, ethyl ether remains the most popular for general use. Ether, as it is manufactured today, has a high standard of purity and perfection. It possesses the widest margin of safety, and has practically no contraindications. It may be administered by open-drop method, which is ideal for instruction and is the safest general anesthetic in the hands of the inexperienced. This technique wastes many times the amount of ether necessary, is slow of induction, and to many people it is very unpleasant. Carbon dioxide induction for open-drop ether is rapid, pleasant, and safe. Ethyl chloride may be used as induction for ether, and is both rapid and pleasant, but not without considerable danger. Ether may be administered with oxygen by means of a gas machine, with or without a closed system.

Vinesthene or divinyl ether is so volatile that it lends itself only to the closed method, and as an adjunct to the gases. It is more pleasant and more rapid than ethyl ether. It is four times as potent, and consequently more toxic.

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* Presented before the Indianapolis (Marion County) Medical Society on October 16, 1945.

Nitrous oxide, a pleasant, non-irritating, non-toxic and non-inflammable gas, was thought early to be the ideal agent, and once more is assuming great popularity. In the recent war this gas was the most widely used gaseous agent. It is a very impotent gas, and is applicable only as an induction agent or for operations requiring very light anesthesia and very little relaxation. To attempt more with this agent alone is to invite asphyxia. To administer this gas alone, one must be familiar with the physiological effects, signs, and treatment of oxygen lack. A safe and well-balanced anesthesia may be obtained by combining nitrous oxide with a more potent agent, such as ether or pentothal. These combinations were usually employed in anesthetizing the severely-wounded casualties in Europe.

Ethylene, introduced in 1923, is a more potent gas than nitrous oxide and allows for the administration of a greater percentage of oxygen. Ethylene has an unpleasant garlic taste and odor. It is both inflammable and explosive. It increases saliva and mucus, and is frequently accompanied by distressing nausea and vomiting. Ethylene retains a limited vogue in America, but has been given up entirely in England.

Cyclopropane is a nonirritating, 100 per cent potent gas. Since 1933 it has been used extensively, and has threatened to displace all other gaseous agents. The desirable qualities of cyclopropane are its rapidity of action, pleasantness, shallow quiet respiration, relaxation, and particularly the high percentage of oxygen with which this agent is administered. This gas is highly explosive and is so potent that the patient may quickly pass into profound anesthesia. It is rapidly absorbed, and lung collapse may result therefrom. There is clinical suggestion of a direct toxic effect on the heart. Administration of this gas requires a high degree of skill and much experience. Proper safeguards are necessary to prevent explosions. The hazards of this agent were such as to prohibit its use in the armed forces with very few exceptions.

Pentothal Sodium has been one of the greatest contributions to anesthesiology. Introduced in 1934, this agent, according to Ludy, has displaced all other methods by approximately 25 to 50 per cent in civilian practice. Certainly it often exceeded this percentage in military practice during World War II. Pentothal has today become synonymous with intravenous anesthesia. The ease with which it can be transported, apparent simplicity of administration, quick recovery, and freedom from fire hazard made a strong appeal to all of us in the armed forces. The pleasantness of induction and the rapidity appealed to the wounded soldiers. This anesthetic was commonly requested by the battle casualty. Pentothal proved adequate when used alone in operations of a minor nature, which required very little relaxation. It is very useful as an induction for inhalation anesthesia and as a supplement for local, regional, and spinal anesthesia. In the past few years anesthetists have broadened the use and application of this agent. This has been accomplished by using an endotracheal tube and a combined type of anesthesia. This has allowed for its use in what were previously considered contraindicated procedures, such as operations about the nose, throat, and abdomen. For the inexperienced, only the rational use of pentothal is advocated. Pentothal Sodium is a powerful respiratory depressant and is potentially dangerous in the hands of the inexperienced. By them it should be attempted only in the very brief, minor cases requiring a light depth of anesthesia. The rational use of pentothal continues to demand that it not be used in operations about the oropharynx and nasopharynx. In these cases it is difficult to maintain a clear airway, because of the danger of aspiration and the hyperactivity of the pharyngolaryngeal reflexes. It should not be used if the patient has dyspnea, respiratory difficulty, or cardiac disease with decompensation.

There is no doubt that pentothal will continue to play an important role in modern anesthesia. This method has many advantages. Likewise, it possesses limitations and dangers. A word of warning is indicated, lest our enthusiasm be overzealous and detrimental to a very fine agent which well deserves a bronze star for its meritorious service in the recent war.

Spinal anesthesia has been popular because of the profound relaxation accompanying it. It has been more popular, I believe, with surgeons than with patients. In recent years many improvements in drugs, spinal puncture needles, and a much better understanding of the physiology and mechanism of spinal anesthesia has resulted in eliminating many of the dangers and untoward side-effects previously experienced with this type of anesthesia. The safer and more satisfactory spinals have been with operations below the diaphragm. The lower the operation, the safer the spinal anesthetic, as the dose is smaller. Present-day complications of spinal anesthesia are usually due to the anesthetic creeping too high and producing respiratory failure, or circulatory collapse due to paralysis of sympathetic nerves with resultant vasodilatation. Such complications are usually produced by too large doses, unwise choice in type of patient, and unfamiliarity with methods of prevention.

Four years ago continuous or fractional spinal anesthesia was introduced. This technique substitutes the multiple, small and safer doses of the drug for the large single dose. My most satisfactory results with this method were obtained in prolonged operations for repair of peripheral nerves in the lower extremities. Spinal anesthesia has been used extensively in the armed forces. This was true especially in elective surgery, such as hemorrhoidectomy, hernioplasty, appendectomy, amputations, and genito-urinary and orthopedic surgery. The average soldier is young, robust, and in good physical condition, and this has been a large factor in the success of spinal anesthesia in military practice. The safety of the method in

regard to fire hazard has made it popular aboard ships. Spinal anesthesia is contraindicated in marked circulatory instability, debility, and diseases of the spine. Advisability of this anesthesia in bowel obstruction, open bowel work, and peritonitis is questionable. It is inadvisable in patients recently resuscitated from shock, and consequently was used very little in surgery of the severely-wounded.

All the peripheral nerves as well as the cranial nerves are subject to blocking with anesthetic solutions. This has resulted in local, regional, and block anesthesia. These methods lend themselves to many operative procedures when other methods may be contraindicated or not so desirable. Of the block anesthesias, intercostal, brachial plexus, paravertebral, and caudal have been most commonly used. Nerve blocking has an important role in the field of diagnosis and therapy. While not specifically an anesthetic procedure, the anesthetist by developing dexterity in injecting nervous pathways for surgical therapy may become proficient in similar exercises for the treatment of various painful syndromes. Stellate ganglion block for relief of severe asthma, sympathetic block for the treatment of angina pectoris, paravertebral block in vascular injury and thrombophlebitis, and spinal block in the management of toxic goiter are some examples of this type of therapy.

Endotracheal intubation for anesthesia was popularized and advocated by Magill and Rowbotham, of England, following World War I. In 1928 Guedel and Waters, of this country, proposed an inflatable cuff on the outside of the endotracheal tube in order to make it airtight. This technical procedure facilitates positive pressure anesthesia and insures an effective means for artificial respiration while permitting aspiration of the tracheobronchial tree—all of which are of tremendous importance in thoracic surgery.

Maintenance of a clear airway is of vital importance in general anesthesia. Interference in the airway may be due to blood, mucus, or aspiration of vomitus or foreign bodies. When this cannot be effectively removed by catheter suction, bronchoscopic aspiration should be available. By reason of his familiarity with the larynx and his experience in endotracheal intubation, the anesthetist can easily acquire the ability to perform such bronchoscopic aspirations. Such a procedure is indicated occasionally in postanesthetic atelectasis. The value and benefits of bronchoscopy before and following anesthesia were often demonstrated in our recent military experience. Endotracheal anesthesia and bronchoscopic aspiration were used almost routinely for all chest and abdominal cases.

Carbon dioxide absorption by means of a canister of soda lime permits the closed technique of administering inhalation agents. This rapid and complete control of the carbon dioxide content of the anesthetic mixture allows the anesthetist better control of respiration; hence, better control of the anesthesia. Body heat and moisture are conserved, and there is less tendency to shock. Breathing is usually quiet and effortless, which saves the patient energy and is a boon to surgeons in abdominal surgery. Satisfactory relaxation is produced with a great saving in the amount of agent used, as compared with open techniques. There is less fire hazard from static spark, because the interior of the closed system is continually drenched by moisture condensed from the exhaled gases.

Modern anesthesia includes modern methods of resuscitation, and should be of aid whenever such procedures are required. Such therapy includes the use of a mechanical respirator; inhalation therapy with oxygen, helium, and carbon dioxide; and intravenous use of plasma and blood. These procedures may be required during anesthesia. They may likewise be required in the management of shock, in cases of poisoning (barbiturate, cocaine, carbon monoxide, et cetera), and in the treatment of excited states, such as convulsions and hysteria. Anesthesiology offers help, not only to surgery, but to the entire practice of medicine.

Some of the present-day practices in modern anesthesia have been presented. Suggestions have been made as to the modern and future applications of anesthesiology. Next year marks the centenary of Morton. One hundred years ago anesthesia was born—today it has come of age.

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## ABSTRACT: PENICILLIN CANNOT REPLACE SURGERY IN LUNG INFECTIONS

Penicillin cannot serve as a substitute for surgery in the treatment of empyema, according to J. Karl Poppe, M.D., of the Department of Surgery, Washington University School of Medicine, St. Louis.

Writing in the October 6 issue of *The Journal of the American Medical Association*, Dr. Poppe, who is also associated with Barnes Hospital, says that in the early stages of the infection penicillin may be effective but to "use penicillin to avoid drainage of . . . pus appears to represent poor judgment and undue optimism."

Although the author believes there is a possibility of arresting the infection over a period of months with large doses of penicillin, he points out that this can be done only at great expense to the patient. Moreover, there is a tendency toward an unsatisfactory result in such treatment, he said.

According to Dr. Poppe's experience with penicillin in more than one hundred fifty lung cases of all types, the best treatment is to use penicillin extensively during the first two or three weeks after the onset of the infection in an attempt to prevent the development of empyema. If this fails, penicillin cannot take the place of drainage by surgery. The pus in the chest cavity must be drained if it has accumulated, and damaged tissue must be cut away.

# "TYER" USED IN GALL BLADDER SURGERY

FRANKLIN E. HAGIE, M.D.
RICHMOND

In doing a cholecystectomy on a patient with a high liver and a thick abdominal wall, we often have trouble in tying the cystic duct and the cystic artery. With the depth and the limited space in which to make the tie, one is often called upon to meet a rather difficult situation. In such cases I have been using a "tyer" which I have devised, and which I find of great help, changing a difficult situation into an easy one.

FIGURE I

*The "Tyer"*

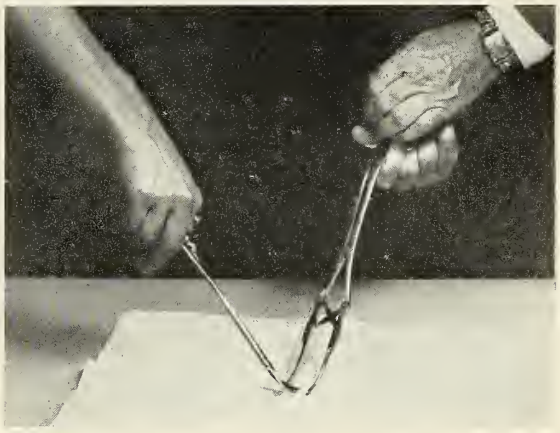
This devise is a Goodell Baer uterine dilator with the check near the handles removed, and a small ring welded near the end of each blade on the outer surface. The curve of the blades readily takes the tie under the clamped forceps applied to the duct or artery.

Figure I shows the tyer, which has a spread of one inch—no more. I slip a pliable water-softened piece of chromicized catgut under the forceps, on the duct, starting the tie with my hands, and then threading one end of the catgut through each ring. Holding the ends of the catgut in the left hand, and by dilating and closing the tyer with the right hand, as shown in Figure II, the first knot is carried down under the forceps and tied tightly.

I then withdraw the tyer, start the second knot, re-thread and force the knot down in the same manner as before, thus completing the tie, as shown in Figure III. The cystic artery is then tied in the same manner. In this way I get good, firm normal ties with the hands remaining outside the abdomen. The tyer can be used in other difficult fields of surgery, but in cholecystectomy I think it particularly offers a real help.

FIGURE II

FIGURE III



*Technique used in tying.*

## ABSTRACT

### REPORT DRUG THIOURACIL NOW CURES THYROID GLAND INFLAMMATION

Two Seattle physicians report that the drug "thiouracil," which previously has been used in toxic goiter, has been employed successfully in the cure of thyroiditis.

In *The Journal of the American Medical Association* for September 22, Dr. Brien T. King and Dr. Leo J. Rosellini state that of eleven cases diagnosed as thyroiditis and treated with thiouracil, eight were symptom free in one week, and in all the gland enlargement completely disappeared.

Previous treatment of this thyroid inflammation has included iodine, rest, hot applications, ice bags, and x-ray. The sulfonamide drugs have been tried, but so far they have been of little benefit. Prior to September, 1944, the only treatment that definitely seemed to shorten the course of the disease was x-ray.

In describing the disease, the authors stated that in a considerable percentage of all cases there had been a history of recent mouth or throat infection. The disease is usually of sudden onset, occurring in a previously normal gland or one slightly enlarged. They emphasize the fact that they have not seen it develop in a previously-existing goiter of any type. It is associated with slight to moderate enlargement of the thyroid gland, which is usually quite tender and painful.

# EYE EXAMINATIONS AS CONDUCTED IN THE NAVY*

COMMANDER D. H. ROW†
Medical Corps, United States Navy
WASHINGTON, D. C.

The eye problems encountered in a large naval activity, such as the Great Lakes Naval Training Center, vary directly as the visual standards are varied for acceptance of the recruits and inductees into service in the Navy. It has only been within the last year that myopes have been able to qualify for naval service—that is, myopes of sufficient degree to cause considerable reduction in their visual accuity. The stress on the importance of myopia in naval service is based on the fact that a myope standing a deck watch with salt spray in his face cannot see effectively through his spray-bespattered glasses, and, of course, without his glasses he is quite lost visually in direct relation to the degree of his myopia.

At the present time general duty minimum visual standards of inductees are 6/20 minimum vision in either eye, with a minimum binocular vision of 10/20. In the Navy we use a different method of determining visual acuity than has been standard civilian practice. Instead of using the familiar Snellen Chart with the large letter E at the top (usually rated as 20/200 with progressively smaller letters in the lines below down to 20/20, and, in most cases, down to 20/15 and 20/10), we use charts having only 20/20 lines for the first six or eight lines, followed by three 20/15 lines. In using these charts we rate a subject whose visual acuity is below 20/20 by moving him nearer the chart until the line of 20/20 letters can be read. If the inductee cannot read the series of 20/20 letters until he has been moved up to a distance of ten feet from the chart, we record his vision for the eye under consideration as 10/20, which, in civilian terms, would be 20/40.

Men reporting at the receiving building of the center are given a general physical examination, which includes a routine external ocular examination. At this time we look for pupillary equality, evidence of external ocular disease (such as muscular imbalance causing obvious lack of parallelism of the eyes), corneal scars, pathology of the iris, chronic conjunctivitis and blepharitis, pterygium, ptosis, chalazion, and, if a flashlight happens to reveal such trouble, gross lenticular changes. Occasionally recruits will be found wearing contact lenses in an effort to slip their myopia through the examining line unrecognized.

Color perception is tested routinely by means of the pseudo-isochromatic color plate test. This test results in three classifications: (1) normal color perception; (2) moderate color deficiency; and (3), extreme color blindness. The first two groups are acceptable for general duty in the Navy, while the cases of extreme color blindness are classified for limited duty where they will not be required to read signal flags or observe running lights of vessels and signal lights of various colors.

The foregoing tests are followed by others for central visual accuity. If vision is below 20/20, corrected by glasses, or below the minimum standard of 10/20, binocularly unaided, further examination of the eyes follows. Funduscopic examination is given, as are visual field tests when indicated.

Because of the high incidence of myopia among men examined for the service, the classification known as "Special Assignment" comes into prominence. Under this classification myopes with a visual accuity of not less than 2/20 in each eye, correctable with glasses to 10/20 in each eye, receive duty status where deck watches will not be required of them. (The eyes must, of course, be free from disease.)

Of all recruits physically examined, approximately thirty per cent are held over for more detailed eye examinations, and to have their visual defects classified. Of this percentage, only three per cent are rejected. (Since all the men examined by us have been through previous check-ups, the figures quoted here do not represent a true picture of the number of men rejected because of visual defects, since our examination is, at the very least, a second screening.)

Special eye examinations are given to all men who have finished basic training and who volunteer for such specialties as submarine, motor torpedo boat, combat aircrew, armed guard, range finder, signal man, quartermaster and certain other groupings. These examinations vary to meet the needs of the specific service being considered, but all have in common the requirement of good vision without aid of glasses. Other classifications, such as radio technicians and yeomen, can use men with myopia and other refractive errors.

Another type of special examination is one given to both enlisted men and reserve officers to determine the effectiveness of their night vision. In this test the candidate is placed in a dark room for at least a half hour, and is then tested with a radium plaque. The plaque is held about five feet away from the man being tested, and a small T-shaped object is moved to different positions on the fluorescent surface of the plaque. A score is kept of the candidate's accuracy in recording the various positions of the T. Men with low peripheral rod

* Presented before the Indianapolis (Marion County) Medical Society, at Indianapolis, on January 16, 1945.
† From the United States Naval Dispensary, Navy Department, Washington, D.C.

vision can be identified, while men with better-than-average night vision can be placed on duty aboard ship as night lookouts.

The most exacting eye examinations are given to the Naval Academy candidate. In these instances we are dealing with young men, usually of sixteen to eighteen years of age, who, if accepted, will undergo three or four years of intensive study. No candidate is acceptable who has any degree of myopia whatsoever under cycloplegia, even though he may read 20/20 easily before the cycloplegic is administered. The tendency for myopia to be progressive in young people, especially when much bookwork is involved, is well known. Such candidates are therefore invariably rejected by the Academy.

There are also exacting tests in muscle balance for prospective range-finder operators, as well as limits on interpupillary distance in the same group. In addition, there are the routine refractive examinations of the recruits who come in with low visual acuity, and who have never worn glasses, and also prescriptions for replacement of broken lenses.

Surgery for chalazion, acute localized infection of the lids, corneal ulceration when indicated, and hospitalization and treatment of cases of intraocular diseases are all a part of the activity of the eye service of the Navy.

The physical examination for enlisted personnel of the Regular Navy requires considerably better vision than for the V-6 classification, which is the designation for U.S.N.R. To qualify for enlistment in the Regular Navy the candidate must have a vision of 15/20 in either eye, correctable to 20/20, with no active disease allowable.

In the officer groups requirements vary as to the needs of the group or classification under which the candidate is trying to qualify. Deck officers must have a vision of 18/20 in either eye, correctable to 20/20, or in some instances, DVS, 15/20 vision either eye is acceptable if correctable to 20/20. These classes are known as "line" officers.

There is also the group known as staff officers, such as supply, engineering, medical, and dental officers. Here the requirement is only 12/20, correctable to 20/20. All officer candidates must have normal color perception, that is, they must pass the color plate test.

## ABSTRACT

### MEDICAL SERVICE GROUP FAVORS FEDERAL SUPPORT OF RESEARCH

A five-member subcommittee of the Committee on Postwar Medical Service, which was organized by the American Medical Association, the American College of Physicians, and the American College of Surgeons in June, 1943, has approved in general the recommendations of the report recently submitted to President Truman by Dr. Vannevar Bush, director of the Office of Scientific Research and Development. The Bush report urged continuance in the postwar period of the coordinated and intensified research that did so much for the advancement of medical and other sciences during the war.

An analysis of the subcommittee's study appears in the October 6 issue of The Journal of the American Medical Association. It was prepared by Chairman Francis G. Blake, M.D., dean of the Yale University School of Medicine; Frederick A. Coller, M.D., professor of Surgery, University of Michigan Medical School, Ann Arbor; Victor Johnson, M.D., secretary of the Council on Medical Education and Hospitals of the American Medical Association; W. W. Palmer, M.D., professor of Medicine, Columbia University, New York, and Rev. Alphonse M. Schwitalla (S.J.), dean of the St. Louis University School of Medicine.

After citing several reasons set out in the Bush report for federal support of research, the subcommittee said that it "accepts the force of these arguments and agrees with the conclusions, subject to appropriate safeguards," adding:

"The subcommittee . . . favors federal support of research: it is of the opinion that the support of scientific research by the Federal Government presents a challenging and compelling opportunity for government to foster the public welfare by assisting in the support of scientific research. To be most effective, this support should leave the policy, personnel and method and scope of research to the colleges, universities, and research institutions themselves. Institutional and personal liberty in research should be fully safeguarded. The responsibility for such safeguards should be entrusted to men of scientific achievement, knowledge, and leadership."

Commenting editorially on the subcommittee's report, the A.M.A. Journal said:

"Among the points emphasized by practically every medical group that has considered the problem are the following:

"1. Voluntary philanthropic foundations, universities, and similar agencies have contributed greatly to scientific, and particularly to medical, research in the United States. The establishment of a federal agency with vast funds might well obstruct, if not destroy, such voluntary efforts and thereby do more harm than good.

"2. The Federal Government aids research on cancer and on tuberculosis, as well as research on some other conditions, by special grants of funds. Measures have been introduced into Congress for the spending of enormous funds, particularly in relationship to the study of neuropsychiatric disorders and dental conditions. Any program developed by the Federal Government should take into account the desirability of coordinating and integrating research on all medical problems proportionately to the need for such research, and to the importance of the problems to be investigated.

"3. The advancement of medical science and the improvement in health in recent years have been so great that both Presidents Roosevelt and Truman emphasized the medical aspects of research in their messages to Congress. Nevertheless, some of the measures that have been proposed for establishing a National Research Foundation fail to make provision or direct representation of medicine in the governing boards to be established, leaving it rather to subcommittees to undertake consideration of the medical problems.

"4. Most of the measures that have been introduced provide for fellowships to encourage young men who seem to have aptitude for research, and for sections to be devoted to the dissemination of information and knowledge that may be developed. From the point of view of medicine there should be coordination between the special agencies created for education and for the dissemination of information with the agencies created specifically for research, and also with the central board.

"5. The question of patents constitutes a special problem. Discussion of ownership of patents and the licensing of manufacturers under such patents may well come to be the stumbling block over which the whole proposal may fall.

"Possibly the ideal concept for the control of a National Research Foundation such as is proposed would be the creation of a general controlling board to include a chairman and members who would themselves be chairmen of various subsidiary committees. By such a technic adequate representation of each of the interests concerned would be provided, and with it better coordination for the management of the Research Foundation."

*THE JOURNAL*

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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NOVEMBER, 1945

# Editorials

## THE FRENCH LICK SESSION

After a long period of watchful waiting and wistful thinking, our Executive Committee last August decided to cancel the annual meeting of the Indiana State Medical Association, which was scheduled for French Lick sometime in October. This was in accordance with the order of the O. D. T., to the effect that all conventions, at which the attendance would exceed fifty persons, were out until such a time as transportation facilities had been restored to a near-normal schedule.

At the same meeting the Executive Committee left the date for a House of Delegates session in the hands of President Forster, trusting that we might at some time before the end of the year receive permission for such a meeting.

However, with the rather sudden end of the Pacific war, O. D. T. came through with an announcement that such meetings as state medical societies are wont to have would be permitted, whereupon there was a mighty bit of scurrying about at headquarters. After much conferring, and many phone calls, it was decided to hold the meeting at the French Lick Springs Hotel, on November 6, 7, and 8.

Several minor changes in the program were necessary because of the short time left for preparations. This year only general meetings are held —no section meetings.

A preview of the program assures us of a most interesting and informative array of speakers, many of them, as usual at our state gatherings, being from outside Indiana. Plans are made for the golf tournament to be restored to its pristine splendor, and if enough entrants are assured, the skeet match will also be carried out. Honorable Ralph F. Gates, Governor of Indiana, will be the guest speaker at the annual banquet. The usual entertainment feature for the dinner meeting will also be provided.

While the belated announcement that a meeting would be held will in some degree affect the attendance, it is hoped that members throughout the state will be present for the party. An added feature will be provided by the attendance of many of our members who have been missing these last three or four years, because of their having been in the armed forces. By November first it is expected that a sizeable group of Indiana members of the Medical Corps, both Army and Navy, will have returned to their homes, and it is but natural that they will want to attend this get-together affair.

Early November is an ideal time to visit southern Indiana; Dame Nature will have completed her scheme of fall decorations, and the hills and vales will be garbed in their finest splendor. Many of the birds that in past years have been a great attraction to nature lovers will have left for their southern vacations, but there are plenty of those who are hardy enough to stay around until Old Man Winter sets in. Then, too, the squirrels, both the large varieties and the impudent little devils, the chipmunks, will be on hand as usual, begging for nuts.

There is no finer spot in which to spend a few days than at French Lick, even though one does not go in for the waters and the baths—a more restful spot we never have known. Hotel facilities, as are well known to most Indiana physicians, are of top variety, and the service, cramped as it was during actual times of war, is again restored to a near-normal basis.

At the time of this writing we hope to see all of you at French Lick, and in our next issue we will give an account of our observations at this memorable occasion.

America is now making
its last appeal for
VICTORY BONDS
Buy now!

## A DIFFERENT TYPE OF PUBLICITY

Some time ago we received a letter from a Chicago man whose letterhead indicated that he is a "Professional and Public Relations Counselor." An extract from the letter reads: "Enclosed please find a copy of a very excellent article which appeared in the *American Journal of Surgery*. Copies of this reprint are available to any of your readers by addressing . . . (the name and address of a Chicago physician). I will personally appreciate a copy of the digest appearing in your magazine. I thank you, and will be happy to reciprocate your kind courtesy whenever the occasion may afford."

We at once made inquiry through the Bureau of Investigation of the American Medical Association, and learned some interesting things about this "counselor." It seems that for some years he has served as editor of the *National Drug Clerk*. Along in July, 1933, *The Journal of the American Medical Association* published an article, prepared by the Bureau of Investigation, under the head, "The 'Patent Medicine' Big Stick."

In that article there was reproduced a letter written on the letterhead of the United Medicine Manufacturers of America, whose offices were at that time located in Washington, D.C. This letter was signed by a man of the same name as the eminent "counselor" under consideration, giving his title as "Chairman, Publicity Committee."

The letter was addressed to a radio station at Canton, New York, and complained about some statements made over that radio pertaining to patent medicine. A part of another letter, signed by the same man, was used in the *J.A.M.A.* article, this one addressed to the *Malone Farmer*, in which had appeared an article entitled "Patent Medicine Testimonials are Broadcast Topic." The writer complained about this article, declaring that such publicity was detrimental to "reputable manufacturers, as the article does not differentiate between the reputable manufacturers who are observing the law and doing a real service for humanity, and the type of manufacturer referred to."

There we have somewhat of a background of the chap who now sets himself up as a "counselor," going into a new field, at least one that never before has come to our attention—that of "plugging" the writings of physicians, and seeing to it that these articles get full publicity. We believe it reasonable to presume that the physician in question pays a fee for this "service," since the eminent "counselor" hardly could afford to maintain an office for gratuitous services.

For a good many years we have been somewhat of a student of medical publicity, and are familiar with the older types of this professional degradation, but this comes as a new slant, and we are wondering just how far it will go. It could be stopped right now if *all* medical journals would adopt a single tactic, that of permitting such requests as made by the eminent "counselor" to go unnoticed—not even giving him a reply.

This medical publicity thing seems to go in cycles, breaking out with renewed fervor every few years. Local and state organizations have studied the problem, have "resoluted" against it time and again, and on some occasions the offenders have been haled before the authoritive body of the local medical society for a good going over.

But here we have a new slant of publicity—a professional "plugger," which certainly increases our problem. We wish that every medical journal in the country who receives such a request from this most eminent "counselor" would give full publicity thereto, even to the point of naming the physician who is sucker enough to fall for such a racket.

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## MEDICAL QUACKS IN INDIANA

Early history tells us that from the beginning of Medicine there were imitators and pretenders, folk that we of this date know as "quacks." At times we have felt that Indiana had more than her share of these undesirables, but it seems that they have been no more numerous here than in most states of comparable population.

We have had some personal experience with these violators of the law, having been instrumental in all but putting an end to the era of "Men's Medical Specialists" in Lake County, causing some seven such places to close shop and get out of the state.

A few years ago the Indianapolis Better Business Bureau, which has for a long time done a good job in cleaning up questionable practices in the business world, became interested in one form of quackery then extensively carried on in the Capital City—the cancer quacks. After a long period of investigation, carried on at considerable expense, the Bureau filed charges before the Indiana State Board of Medical Registration, seeking to revoke the license of one Charles C. Root, of that city. After hearing the case for several days the board voted to revoke his license, a rather effective measure for some time to come, as regards cancer fakes.

In recent years the bureau has turned its attention to the horde of "drugless healers," many of whom have felt that once they had a state license to practice a specific "system" they could take full advantage of their bit of official paper from the State of Indiana, and accordingly blossomed out as fully qualified healers, not only as regards their own school, but by practicing medicine in the same capacity as the medical profession. The Bureau had a most excellent investigator on the job, and in no time he began to turn up some very flagrant violations of the Medical Act.

It would be impractical for us to enumerate the many who were brought to trial, either before a

court or before the State Medical Board, hence, we will mention but a few of the more spectacular cases. Probably heading this list was one Hiel E. Crum, of Indianapolis, legally licensed both as a chiropractor and a naturopath. An ingenious sort of chap, Crum came up with a patented apparatus which he called the "coetherator." This was a wooden box with a lot of contraptions attached thereto, the dials, lights, et cetera, rivaling the instrument board of a B-29 plane.

The more he played with the thing, the more he claimed it would do; not only would it cure the ills of mankind, but it would fill teeth, kill dandelions on one's lawn, and fertilize the garden. All this evidence came out in the hearing before the board, which, of course, revoked the two licenses held by Crum.

And how the gullibles flocked to his office! They came in such numbers that Crum was taking in plenty of money; he had a "good thing," and meant to hang on to it if he could.

Therefore, he appealed the decision of the board, the Marion Circuit Court upholding the decision of that body, and from there he went to the Indiana Supreme Court, which also sustained the action of the board. The opinion in this case, by the way, was written by Justice Curtis Shake, of Knox County, one of the sanest, most readable decisions that has come to our notice. Crum, so far as is known, left the state immediately after the case was closed. Other similar practices have, however, continued in Indiana.

William F. MacDonald came to Gary several years ago, possessing a license for the practice of optometry. When the 1927 amendment to the medical law was enacted, he filed a request for licenses as a naturopath and, as we recall it, a physiotherapist. It was generally known that he was practicing medicine, claiming to be an ophthalmologist. The bureau investigator found plenty of evidence of these violations, and later one of his drugless licenses were revoked. However, he continued to treat eye diseases, was found guilty thereof by the Lake Criminal Court, and a fine was paid. He still holds his license as an optometrist.

Alma Cox, of Crown Point, was checked by the bureau investigator, who found she was using a "Radioclast" outfit, which had been proved worthless as a diagnostic and treatment agent. On hearing the evidence the board revoked her license. She took an appeal, and the case was venued to the Jasper County Circuit Court, where the action of the board was sustained. Miss Cox then filed a suit for damages against the bureau, the officers and members of the Executive Committee of the Indiana State Medical Association, including the editor of THE JOURNAL, and others. Nothing further was heard about this suit. In passing, it may be mentioned that similar suits were filed by two or three others whose licenses had been revoked.

J. R. Scherer, who had an office in the State Life Building, at Indianapolis, as well as one in Irvington, put up a stiff fight to maintain his license as a drugless practitioner. Investigation showed that he was not only practicing medicine, but that he had letterheads on which the title "M.D." appeared. He also dabbled with the "Koch cancer treatment." His license was revoked, and on appeal and venue to the Hamilton County Circuit Court, the action of the board was reversed. The board appealed to the State Supreme Court, where the action of the board was upheld.

These are but a few of the many cases investigated by the Bureau. We have not touched upon the case of the Clawsons, the "hot hand" healers down Martinsville-way.

The September number of the *Indianapolis Better Business Bureau Bulletin* lists an even sixty cases which they have investigated, and in every instance have they succeeded in putting these violators out of business.

Ignoring for a moment the enormous waste of money spent by the gullible folk of Indiana in calling on these fakers, there is the more serious side to quackery—that of delay in getting appropriate treatment, delay that in too many instances costs a life. The bureau is to be highly commended for its many successes, and it is hoped that it will be able to continue its crusade until Indiana is reasonably free of quackery.

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## STREAM POLLUTION

THE JOURNAL consistently has advocated more stringent laws and more definite enforcement of these laws, relative to the pollution of our natural waters. For several years we have commented on this subject, giving due credit for whatever action may have been taken by our state authorities in these matters.

Now it seems that the whole subject is up for action, and that at long last we have a group empowered to do things and to take drastic action when necessary.

In northwestern Indiana, in Lake County in particular, we already see good results from an action taken several years ago by the Indiana State Board of Health relative to the pollution of Lake Michigan. Four cities in that county were pouring raw sewage into this body of water, the same water that is used for domestic purposes by the entire group. Today three of these cities have in operation modern sewage disposal plants, while the fourth city has a plant almost ready for operation.

The group officially empowered to study the problem and to enforce the laws already in effect, and, probably, to ask for additional reinforcements in the law, at the hands of the legislature, has announced a definite program which sounds as though they mean to carry on a fight for the restoration of our waters.

There is no occasion to go back into ancient history regarding this problem in Indiana; the details are known to most everyone who in past years has been interested in wild life and the natural beauty of our streams and lakes. We do not need to go into a detailed description of the havoc wrought in our waters by strawboard works, by canning factories, slaughter houses, and institutions of that sort. Most of the older men in our profession have seen, first hand, the results of an utter lack of control of factory wastes, et cetera.

Now that the Stream Pollution Control Board is definitely set up, and at work, we should offer them all support at our command. And the doctors can do much along that line by talking to the people of the state as they go about their daily duties.

During our time we have seen a stream pass from the day when it teemed with fish that delighted the angler—and there were hundreds of these—to the time when practically no living thing of economic value was to be found in those waters.

We recall our beloved Wild Cat creek, the stream from which we "extracted" our first fish, a little sunfish, this some sixty-five years ago. Later on, when the strawboard plants, up Kokomo-way, poured their wastes into the stream, dead fish lined the banks of the creek. It was a matter of several decades ere the stream was cleared to the degree that fish had a chance to live therein. And this was true of hundreds of creeks and rivers over the state. Our lakes fared little better in too many instances; we have in mind a lake that was lined on all shores by summer cottages, and until recent years there was no effort to stop the constant pouring of domestic sewage into that beautiful body of water.

We have spoken of the effect of these pollutions on wild life; but there is a more important phase of the problem—that of endangering human lives. Time was when it was considered quite safe to drink freely from many of our waters—not so in recent years. Each year the State Board of Health issues a warning to vacationists: "be careful about your drinking water; even though the water is clear and cool, it probably is not potable."

It will take years to correct the many evils that face the new board, but we have an abiding faith in that body; a check of the membership, plus a review of the law creating it, indicates that these men have begun upon a huge task, one that they confidently believe can be completed.

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## A SALUTE!

### ARMY MEDICAL DEPARTMENT GETS SIX PER CENT OF WORLD WAR II DECORATIONS

Of the 1,400,409 decorations given in World War II in recognition of meritorious service and gallantry, six per cent were received by Medical Department personnel, according to a biennial report by General George C. Marshall. These figures are exclusive of the Air Medal and the Purple Heart.

# Editorial Notes

The annual meeting of the Secretaries-Editors, usually held in November of each year, has been postponed until early in 1946. Due to the lateness of the House of Delegates meeting, American Medical Association officials find themselves put to it to arrange for the numerous other meetings usually set for the latter part of the year.

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Newspaper and magazine publishers are facing a decided increase in postage rates for their publications. Hearings are set by the Post Office Committee of the House of Representatives, at which time the matter will come up for serious consideration. While we have to agree that our postal rates have been rather low, any marked increase in rates will have a decided effect on most state medical publications. What with the increased cost of paper and the decided upping in printing costs, those in charge of such publications already have to cut all corners in order to make ends meet without increasing the subscription rates.

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The annual meeting of the House of Delegates of the American Medical Association, to be held in Chicago's Palmer House, December 3-6, promises to be almost historic in character. Not in many decades have there been so many important problems before American Medicine as at this time. Many of these problems have become most acute, and their settlement seems mandatory. While this meeting is primarily for the House, many association members are planning to be present to observe just what is going on. Save for an occasional executive session, House meetings are open to the general membership.

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During the next sixty days our county medical societies will select their official families for 1946. Never in our memory has it been more important that every officer should be selected only after most careful consideration. Nineteen hundred forty-six will be the first full postwar year, and the many problems, professional and economic, will require leadership of the highest order. American Medicine is said to have been at the "crossroads" for, lo, these many years. The war activities have prevented our making a decision as to which road we will take—now we must make that decision. There is too much at stake to use a hit-and-miss action in these elections; we must choose top men for every office. The various war activities have shown just who these leaders are. They have brought forth qualities that for many years have remained latent. We now are in a position to know just who these leaders should be—let's act according to that knowledge!

Although the nursing problem may be less acute, postwar considerations indicate that we still will not have a prewar volume of nurses for some time to come. The American Nurses Association has sent questionnaires to all nurses in the Army Nurse Corps, asking just what they wish to do when they are returned to civil life. From the answers already received it would seem that many of these will want to go into Public Health work; some will take a postgraduate course; some even have asked about the nursing programs being developed in Alaska, as well as in many foreign countries. Thus, it would appear that our service nurses are doing a lot of serious thinking as to what they want to do when they are discharged from the Army.

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Early this summer Governor Dewey, of New York, took action on a bit of proposed legislation by vetoing a certain bill that had been passed by the New York legislature rather hurriedly. This bill would have required the Board of Regents of the Department of Education to admit, for examination and medical licensure, graduates of unapproved medical schools. A New Yorker had written a letter to the *New York Times*, protesting the action of Governor Dewey, introducing the question of racial tolerance in his protest. Although in some quarters there was a shortage of physicians, and those remaining in the civilian effort were saddled with an extra load, there never was a time when it became necessary to let down the bars and admit to licensure graduates of schools notoriously poorly equipped for the teaching of medicine. The racial tolerance question, too, is much overworked by many commentators. A survey of the situation will show that members of all races are graduated from the best medical schools, and that they all receive the same consideration.

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The Indiana State Medical Association will have a banner year in 1946; we make this prediction without the slightest reservation. For four years we have been under restraint, each year finding it necessary to curtail this or that activity. But 1946 will find us going at top speed, using every facility that we found efficient in former years, plus a lot of new ideas put into execution. Among other activities that have been dropped in recent years is the annual Secretaries' Conference, one of the greatest of all the big days in Indiana Medicine, and probably the most important conference we hold. This meeting usually is set for January, and commands a very large attendance. It is the one opportunity when each county society has to "say its say." The Industrial Health Conference should be brought back in an enlarged way, since it probably will combine with its interesting study one of our big problems, Vocational Guidance. Numerous other meetings should be restored and, as we have said, many new ideas will be well worth working out. So, 1946 should—*and will*—be a big year in our history.

The Institute of Life Insurance has issued a bulletin regarding the improvement of health in this nation, even though we have been at war for several years. The communication states that with the many new discoveries in the treatment of diseases, directly the result of our war experiences, this is "expected to be an important factor contributing to the reduction of mortality." They cite some of the wartime health discoveries which may be of future benefit, naming the various uses of blood plasma; the DDT control of germ-bearing insects; immunization against typhus; new advance in plastic surgery; the use of blood by-products, along with many other such discoveries. Truly, the progressive physician will have to do a lot of reading these next few years, to keep up with the ever-advancing medicine, and our journals will have to keep in step by reporting the practical application of this new knowledge.

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Considerable interest is being manifested in the question, "Just when will our Medical Corps officers be released from service?" Many feel that with the close of the war there should be little delay in sending these physicians back home, this feeling being quite prevalent in the families of these officers, in some cases to such a degree that great effort is being made to effect these releases. There are many phases of this problem to be considered. It is true that the actual fighting has ceased, with a resultant stoppage of the thousands of casualties that required medical and surgical attention, but we should not overlook the fact that millions of our troops are still in service, and that millions of residents of devastated countries need medical attention which in many cases they cannot receive from native physicians. Health and hygiene measures still need to be enforced in these areas, all of which require a large complement of trained medical men. A large group of medical officers are needed in transporting troops to this country, including casualties, so that the need continues to be most urgent. Several thousand of these officers already have returned to civilian life, with other thousands to follow in due time, so that there must be some definite setup in the plan of mustering out these men. The policy adopted, "admitting a bit of elasticity," as one official has put it, is as follows:

1. Length of service.
2. Fifty- and forty-year age groups.
3. Overseas combat duty.
4. Overseas duty in rear areas.
5. Needs of civilian medical coverage.

There we have the story, and most fair it seems. There are those who have not been sent out of the country in the line of duty, yet they played an important role in our war activities. Some of them feel that the duties they now are performing could be carried on by less-trained men, and that they, themselves, should be sent back home. However, the "five points" enumerated above would seem to be the most practical answer to the question.

# President's Page

## RECONVERSION OF MEDICAL PRACTICE

A great deal has been said and written concerning the problems of reconverting industry from a wartime schedule of production to a peacetime design for civilian needs. Great as these issues are, affecting the economic welfare of the entire nation, the problem of reconversion also influences practically every field of human endeavor. This is notably true of medical practice, where the questions involving the welfare and health of the people are of paramount concern to all of us.

With the sudden ending of the war, efforts were instituted at once to secure the release of medical men from the armed forces, in such numbers as were practicable, not only to assure care for thousands of casualties, and adequate care to the vast armies of occupation, but also to relieve the burden which the civilian physician has been carrying throughout the war, and to return our service men to their rightful place in society as quickly as possible.

When one considers the fact that some fifty thousand of our younger practicing physicians have volunteered for service in the armed forces, and that the rate of disability or death of the men left for civilian practice has been very high, it becomes apparent that the matter of reconversion, from the medical standpoint, will be increasingly difficult. The medical profession's efficient protection of the health of the civilian population during the war, even though its force has been largely depleted, must remain one of its greatest achievements when its history is recorded.

In addition, the government saw fit to remove premedical students from the exemption list, and as a result the nation now faces a serious shortage of physicians for the postwar period. Present estimates indicate a need of ten thousand physicians for a peacetime Army, five thousand for the Navy, and about fifteen thousand for the Veterans' Administration. A conservative estimate is that thirty-five thousand additional physicians are needed for civilian practice, and that less than half of this number can be provided. Consequently, medicine enters the reconversion period under the handicap of personnel shortage, and the necessity for an early discharge of an adequate number of those now in service must be anticipated in order that the many problems of health matters confronting the profession and the public may be solved.

The threat of socialized medicine, evidenced in the presentation to Congress of numerous bills on compulsory health plans, and the extension of maternal and child care, present another hurdle in the reconversion of medical practice. Not only must we meet the exacting problems of the postwar period, but we are also confronted with the necessity of meeting the challenge of social planners, who would centralize and mechanize the administration of medical services and destroy the time-honored and essential tenet of physician-patient relationship.

In this postwar period American Medicine again must assume a pioneer attitude. In the face of seemingly insurmountable obstacles we must salvage for the future, and for the welfare of the public, a manner of practice and a profession that ranks in the highest realm. From the mortgage of war must arise gifted minds, undiscovered scientists, and intellectual and spiritual leaders upon whom each generation can build the hope and promise of the generation to come.

Surely in the ranks of medicine there are minds of ability, devotion, and determination which can solve the problem of medical care. Twenty-two states have voluntary prepayment plans operating toward the solution of this problem, and Indiana hopes to be added to this list within a short time. But this is not enough; our goal is a nation-wide coverage by a voluntary prepayment program that will protect the people, at a low cost, from the uncertainties of illness and hospitalization. With so much creative human talent employed in devising increasingly beneficial measures for the prevention of disease and its treatment, it is patent that it can also be applied to the perplexing problems in the distribution of medical care. These questions are not so technical, confusing, or entangled in the skein of human relations that they cannot eventually be answered. These services can and will be dispensed without priority rating, requisition, application, investigation, registration, or inquisition; they will be provided in the free American manner, by American doctors, for the American people.

But there are other problems confronting us in this reconversion period, issues such as the re-establishment of previous medical educational standards; a return to a balanced ratio of interns and residents; improvement in medical practice, as a result of developments from wartime research and experience; improvement and extension of hospital facilities; postwar medical education for returning members of the Medical Corps; medical care for the indigent; expansion of health education to all the people through the various media of communication; amplification of health services in industry; assisting the physically-handicapped; rehabilitation of the returning veteran; and solving rural health problems—all of these and many more present a never-ending challenge to the medical profession. The physicians of Indiana accept this challenge, and from their united, patient, and sustained efforts will emerge a solution that will find reflection in the health and happiness of our citizens.

N. K. Forster

# HAIL TO THE THIRTY-SECOND GENERAL HOSPITAL!

(This is a sequal to the article published in the June, 1945, issue of THE JOURNAL of the Indiana State Medical Association, which gave a history of the activities of General Hospital No. 32 until the time of its transfer to Aachen, Germany.)

NELLA H. ROKKE
Assistant Editor
INDIANAPOLIS

*South approach to Main Hospital Building, showing Administrative and Surgical Wing.*

*Prior to the unit's occupation this was the "Stadtische Krankenhaus" (City Hospital)*

*Thirty-second General Hospital, in Aachen, Germany.*

Carrying out the traditions of the Lilly Base Hospital 32, which was formed in 1917, during World War I, the Thirty-second General Hospital has again scored in a world conflict, triumphant in victory—this time under the sponsorship of Indiana University, and under the command of Colonel Cyrus J. Clark, of Indianapolis.

The Thirty-second General Hospital, whose aspiration was "conquest of pain and the relief of suffering," has been a benefactor to mankind, whose record will go down in the history of World War II. However, at the very outset of our interview with Colonel Clark and Lieutenant Colonel Charles F. Thompson, they gave unlimited praise to *every* Indiana physician who has served in World War II, and whose accomplishments have been reflected in the magnificent work they have done. For instance, Colonel Clark said, "Our experience has been that the casualties coming to us from frontline units have had the best of care, and our achievements were of a secondary nature, the main credit going to those who served in the lines ahead of us—the medical officers in the combat units and mobile hospitals. And finally, to the enlisted personnel goes much credit for the excellent operation of our hospital." May we add our bit of praise to Colonel Clark for *his* able command?

The Indiana General Hospital was commissioned in impressive ceremonies at the Indiana University Medical Center's campus on May 13, 1942, everyone present feeling the solemnity of the occasion as the officers and nurses took their oath of allegiance. The unit was activated in March, 1943, after which the enlisted personnel received six months' training, which, Colonel

*Officers' Quarters of Lilly Base Hospital 32.*

*Contrexeville, the site of Lilly Base Hospital 32 (1918-1919).*
*Hotel Royal, one of the hospital buildings occupied by Lilly Base Hospital 32.*
*(Photos taken August 21, 1945.)*

*Hotel de Paris, another building occupied by Lilly Base Hospital 32.*

*Unit B and Officers' Quarters, showing some of the devastation.*

*Power Plant and Unit D, taken from roof of Unit A.*

Clark said, resulted in a smooth-running unit. Unfortunately, 383 of these men were lost through transfer to other medical units prior to embarkation. The unit represented thirty states out of the union, although the complement was made up largely of Hoosiers. Insofar as Indiana was concerned, about one-third of the counties of the state were represented, from Vanderburgh to Lake, and from Vigo to Allen counties. The nursing staff represented the entire state, with additional personnel from eastern and western states. Colonel Clark became the commanding officer of the hospital early in 1944.

The Thirty-second General Hospital has reason to be proud of its tremendous undertaking and achievements. It moved steadily forward, and was recommended by Lieutenant General John Lee, in a letter to Major General Paul R. Hawley, for its performance while in England. Following its arrival in Normandy the unit was split into surgical and shock teams, which for short periods were sent out to the various field and evacuation hospitals to relieve the overworked assigned personnel. It was here that "The rocket's red glare, the bombs bursting in air, gave proof through the night that our flag was still there." They worked in twelve-hour shifts throughout this entire period.

At the end of three months in Normandy, having trained other general hospital units in administration technique, as well as continuing to operate their own unit, they were again moved into a forward area. This time the hospital unit was moved into permanent quarters at Aachen, Germany, a city with a pre-war population of about 150,000, but whose population had dwindled to about 2,000 at the time of the hospital's arrival there. Aachen was a historical city, being the capital of Charlemange's empire, where he was crowned and buried, and was the capital city of the Holy Roman Empire at the time of Charlemange. However, as a result of the one hundred thirty bombings the city had been practically demolished, being only about twenty per cent habitable. Both Colonels Clark and Thompson stated that they did not see how the city could be rebuilt.

At Aachen the picture changed, for here the unit moved into a one-thousand-bed hospital formerly occupied by the Germans, and which had suffered only minor bomb damage, where its facilities were practically unlimited as compared with its former Nissen hut and tent operations. There it became one of the busiest general hospitals in Europe, handling 10,700 cases during the first ten days of operation. About five buildings comprised the unit, which operated chiefly in a modern eight-story building, and the hospital area covered about thirty-five acres. A German industrialist's palatial mansion served as the Officers' Club. The owner had been a typical example of a German industrialist, and was a product of the economic system which existed in Germany since 1933. His factory had been the largest in Aachen, and had originally held a monopoly in the manufacture of umbrellas, later being converted into the production of parachutes during the war period. It is interesting to note that at the time of the food survey in Aachen, for the benefit of civilians, secret compartments were found in this industrialist's home, which contained the choicest Russian caviar, the best Norwegian fish, the best French canned goods,

*Entrance drive and gate to Thirty-Second General Hospital, in Aachen, Germany.*

*Main driveway to Unit A.*

*Unit C—Medical Wards.*

*The unrestored portion of Unit C—the Karen Goering Building—damaged beyond repair.*

*A driveway and the Enlisted Men's Quarters.*

*Nurses' Residence.*

*A view of the Prisoner-of-War Stockade, taken from the top of the hospital.*

*Exit drive and gate.*

cheese, and champagne, and other choice foodstuff from other occupied countries, along with some American Army supplies. This mansion had been the site of the entertainment of high Nazi officials, for the host had been one of the three largest industrialists in the Rhineland. He was convicted as a food hoarder, under one of Germany's old laws which was in force prior to 1933, and his estate was turned over to the Thirty-second General for its use, being taken over by the British when this unit ceased operating, since Aachen is in the British-occupied territory. During the American occupation the hospital was kept up and improved under the unit's supervision, and the slight damage it had suffered was repaired by our forces.

Here the hospital had an opportunity to branch out, with the result that many desirable features were added for the comfort of the patients as well as the officers and enlisted personnel. "In addition to operating a hospital, we really opened a rest center," Colonel Clark said. "It was a spa with eighteen hot mineral baths, with club rooms for both the officers and the enlisted men, and comprised one hundred forty beds. We acted as a rest haven for combat soldiers, patients, and members of our staff, in addition to taking care of our medical and surgical patients. This spa had a dining room capable of seating one hundred twenty people. We gave them top-notch hotel service."

All of the hospital's out-patients came from front-line areas, and since this unit was the farthest advanced general hospital, and had specialists such as could not be contacted nearer the front lines, it received patients from all advance units, many of whom did not require hospitalization, but received out-patient treatment. But it was impossible to transport them daily, or biweekly; therefore, they were lodged in the spa, and were taken from the spa to the hospital rather than by long trips from their unit to the hospital.

During the fighting period the war-weary soldiers had access to the hospital's rest club while on their forty-eight hour passes, and General Sidney Hines sent in at least one hundred men every two days as long as they were close enough, until his forces crossed the Rhine.

The hospital unit took over a sun-bathing and swimming-pool park, the pool being about two hundred yards long and sixty yards wide, and the lagoon comprising about ten acres. With the help of PW labor the hospital's damage from bombs and artillery was repaired. The sports arena was put into shape, with several additions, and included a baseball diamond, three tennis courts, handball, croquet, volleyball, and badminton, which facilities were used by the hospital patients. The lagoon was supplied with boats.

The unit reconstructed a greenhouse and started a Victory garden. Through the activities of engineers and German personnel, and the unit's ability to secure seeds from Belgium, Holland, Germany, France, and the United States, it was able to supply its mess with lettuce, beans, peas, radishes, tomatoes, et cetera. There were also three formal gardens, and all of the walks were bordered with flowers. Part of the unit's duties upon taking over the hospital was the clearing of nine bodies from temporary graves. More graves had been dug but not used. The Germans had to leave so hurriedly that they had been able to provide only temporary graves.

The hospital maintained its own bakery and became famous for its hard rolls, supplying not only its own unit, but other outfits as well.

The living facilities were adequate, the only drawback being that the entire personnel was restricted to the post because of non-fraternization, and, accordingly, the unit had to provide its own entertainment.

The labor problem was largely solved by the use of about five hundred German employees, one-fourth of whom had worked in the hospital prior to the unit's inception, and about five hundred German prisoners. The chief engineer, for instance, had always worked in the hospital. These German employees proved to be very reliable, although about ten were released from the hospital's services because of some inadvertent act or their resentment toward the American occupation. All these employees were screened several times by G-5; in fact, they were continually screened, so although they passed their first screening that did not mean that they would continue to be employed. Colonel Clark said that they found these Germans to be intelligent and industrious, and that without them it would have been impossible to operate satisfactorily that kind of a place. The United States Government paid the ordinary maids on the

wards $3.60 a week, plus giving them their food, but because of the food they received there these German employees would have been willing to work for nothing. The administrative force, of course, had to guard constantly against any violation of fraternization, or letting down the bars, which would permit passing out any information. There were no instances of sabotage.

An interesting phase encountered by the unit was the fact that the Germans had expected the use of gas, and that in the hospital basement a solid air-raid shelter had been constructed, even including a complete emergency surgery. Another thing Colonel Thompson pointed out was the fact that they found some unique, gas-proof, portable cages which had been constructed for newborn infants, and which could be carried about by the mothers.

During its twenty-five months of operation, the Thirty-second General Hospital devoted 65 per cent of its total time in maintaining its own hospital, and 25 per cent of its time in being assigned to other hospitals, a total overseas' activity of 90 per cent.

The following table will show the enormity of the hospital's overseas' accomplishments:

| | | *In-patients* | *Out-patients* | *Total* | *Surgery (Operations)* |
|---|---|---|---|---|---|
| **United Kingdom** | | | | | |
| Fairford and Ellenwood | September, 1943, to May, 1944 | 4,000 | 1,800 | 5,800 | 1,960 |
| **France** | | | | | |
| La Haye du Puits | July, 1944, to November, 1944, | 5,600 | 6,800 | 12,400 | 2,020 |
| **Germany** | | | | | |
| Aachen | February, 1945 to August, 1945 | 25,380 | 28,440 | 53,820 | 4,070 |
| | Total | 34,980 | 37,040 | 72,020 | 8,050 |

Colonel Clark gave the following report concerning the physicians who had been connected with the hospital:

"Although the Thirty-second General terminated its activity as a unit by its disbandment and return from the European Theatre of Operations, the curtain cannot fall at this point, because those of us who have returned and are resuming a place in civilian medicine feel a keen and deep sense of obligation to the former members of our staff who are still serving in the armed forces; to the nurses who volunteered to remain overseas for additional service; and to the greater portion of our enlisted men who are still in uniform, and serving in the Medical Corps of the Army in the various overseas theatres." The staff members were as follows:

Lieutenant Colonel Jack E. Pilcher, of Indianapolis, who went overseas as the assistant chief of Surgical Service, continues to do outstanding work as chief of the Surgical Service of a general hospital in Japan.

Lieutenant Colonel Dennis S. Megenhardt, of Indianapolis, formerly head of the Septic Surgery Division of the Thirty-second General Hospital, is now serving as chief of the Surgical Service in a general hospital in England.

Lieutenant Colonel James M. Leffel, of Indianapolis, is now chief of Surgical Service of a general hospital in southern Germany.

Major Fred C. Reynolds, of Indianapolis, formerly head of the Orthopedic Section of the 32nd General, holds a similar position at Gardiner General Hospital, in Chicago.

Captain J. Neill Garber, of Indianapolis, was reassigned from the head of the Orthopedic Section, at the time the 32nd still functioned in Germany, to a similar position with a general hospital in the Philippines.

Lieutenant Colonel Charles F. Ingersoll, of Grand Rapids, Michigan, who was chief of the X-ray Service, was reassigned to a general hospital in Berlin with the Army of Occupation.

Lieutenant Colonel Carl S. Culbertson, of South Bend, who was chief of the Laboratory Service, continues to serve in the same capacity in an assignment here in the United States.

Major Robert L. Amos, of Newcastle, was reassigned from his position as head of the Urological Section with the 32nd to service in a similar capacity in a general hospital in the United States.

Captain Robert W. Oliphant, of Terre Haute, was reassigned from the head of the Section on General Surgery, of the 32nd General, to a similar assignment in the United States.

*The lake in the recreation park.*

*Sun deck on roof—Aachen in the distance.*

*Sports arena.*

*Swimming pool and recreation park.*

*The Cathedral in Brussels remains unscathed.*

Captain James P. Leathers, from Nashville, Tennessee, who was a member of the Orthopedic Section, has been reassigned to duty in the United States.

Major John R. Haslem, of Terre Haute, neurological surgeon with the 32nd during its entire service overseas, was reassigned for service in the Pacific Theatre in July, 1945, and continues in a similar capacity.

Major William H. Norman, of Indianapolis, who went overseas with the 32nd, and filled an important position on the Orthopedic Service, continues in a similar assignment in a hospital in France, and will, no doubt, soon return from his overseas' duty.

Captain George D. Davis, of Indianapolis, who assisted Lieutenant Ingersoll in the X-ray Service, was reassigned as chief of the X-ray Service of another hospital in France, in May, 1945, and soon may be expected to return here.

Captain James E. Engeler, of Indianapolis, head of the Dermatological Section until late in 1944, continues to serve in a similar capacity in a general hospital in the United States.

Captain William B. Rossman, of Indianapolis, who had served as chief of the Neuropsychiatric Section, was reassigned in June, 1945, to a similar position on the staff of Wakeman General Hospital.

Major Harold R. Vogel, of Pittsburgh, Pennsylvania, who served as head of the Dermatological Section with the 32nd General Hospital, in Aachen, was reassigned for similar duty in a general hospital in the United States, in June, 1945.

Major Donald E. Wood, of Indianapolis, who was executive officer of the 32nd General until his return to the United States, in December, 1944, is at present serving on the Medical Service of the Billings General Hospital.

Captain William F. Hanning, of Indianapolis, on the Dental Service, was reassigned to a hospital in France a short time before the last of the personnel of the 32nd General embarked for return to this country.

Other officers on the Medical Service who came to the 32nd General Hospital as replacements for original members of the staff, and performed duties in a highly-commendable manner, are still serving in the Medical Corps and in hospitals in this country.

Colonel Clark further stated, "Just as upon the arrival of the 32nd General Hospital in England, in 1943, members of the professional service were transferred, because of the preponderance of specially-trained medical officers in our university unit, to fill vacancies in other hospitals or the Medical Corps, so upon termination of the overseas' function of the 32nd General, key men on the medical staff again were transferred and retained in order to maintain the high quality of work by units of the Medical Corps remaining to serve occupation forces in both the European and Pacific theatres.

"Members of the nursing staff also continue to serve in their respective places, not only those who volunteered to remain for overseas' duty, but a considerable percentage of those who chose to remain in the service upon return to the United States, although all of them had sufficient service points to be separated from active duty."

Major James F. Balch, of Indianapolis, head of the Urological Section of the Surgical Service from the time of organization of the 32nd General until his transfer to another general hospital in England, has also been separated from service, and is in private practice in Indianapolis.

Captain William H. Lane, of South Bend, chief anesthestist and in charge of the operating room, has been reassigned to similar duty in a base hospital in the United States.

Lieutenant Colonel Paul J. Fouts, of Indianapolis, lost by transfer in England, is on the staff of the Walter Reed General Hospital, in Washington, D. C.

Lieutenant Colonel Isadore J. Kwitny, of Indianapolis, who served as chief of the Medical Service of the 174th General Hospital, in France, following his transfer from the 32nd General, in November, is at present in Indianapolis on leave.

Captain Otto L. Siewert, of Logansport, returned to the United States with the 32nd and is on terminal leave in Logansport.

Lieutenant Colonel Paul G. Iske, of Indianapolis, is commanding officer of a station hospital in New Guinea.

*V-1 Bomb damage opposite Enlisted Men's Quarters, in Liege, Belgium.*

Captain Donald F. Caseley, of Indianapolis, and Captain G. H. A. Clowes, of Indianapolis, are awaiting reassignment in this country.

Captain James N. Topolgus has returned to his home at Bloomington.

Captain John H. Smith and Captain Robert C. Speas, both of Bloomington, were also with the 32nd General for a time.

Officers who have been placed on inactive duty are:

Colonel Cyrus J. Clark, of Indianapolis; Lieutenant Colonel Charles F. Thompson, of Indianapolis; Lieutenant Colonel Frederick D. Cheney, of Indianapolis; Major Russell R. Hippensteel, of Indianapolis; Major Brandt F. Steele, of Indianapolis; Major Charles L. Mahoney, of Terre Haute; Major David E. Engle, of Elmhurst, Illinois; Major William Gambill, of Indianapolis; Major L. S. McKeeman, of Fort Wayne; Captain Dallas Fickas, of Evansville; Captain Theodore P. Mantz, of Indianapolis; Major Howard D. Cogswell, of Whiting; Major Charles A. Everett, of Indianapolis; Major Glenn Pell, of Indianapolis; Captain Jack Carr, of Indianapolis; and Captain Frank W. Jordan, of Louisville, Kentucky.

The unit had the advantage of being visited by many other Indiana men—medical and line officers, as well as others; in fact, it was sort of a clearing house for Hoosiers during the unit's entire stay overseas, and its guest register was voluminous.

Needless to say that the personnel of the hospital is glad to be back home, as exemplified by Colonel Clark in his quip, "Boy, was I glad to see the monument when we came through Indianapolis on the troop train, and to see that the lady thereon hadn't gotten tired of holding her hand up, for they had told us that the Statute of Liberty was getting tired of standing up, and was sitting down in a rocking chair." He further said, "I intend to cancel my Prudential policy, for that sign they use 'ain't' on the Rock of Gibraltar."

Thus ended the chapter of the Thirty-second General Hospital, which was sent off to war under the strains of the Indiana University band playing, "Indiana, Our Indiana," and whose forward march and tempo remind us of the words and music by Sergeant Alfred Carbuto, in the Marine song, "Get your gear on, we're moving on again," and finally, "Get your gear on, at last we're on our way—We are headed for the good old U. S. A.—Get your gear off, we're over here to stay!"

Indiana's General Hospital has served well in helping to preserve our democracy, so that those less fortunate shall not have fought and died in vain. Again we say, *Hail to the Thirty-second General Hospital!*

*Skyline view of Aachen.*

*Duren—a "modernized" German city.*

*The east bank of the Rhine, near Aachen.*

## HEALTH CONDITIONS IN GERMANY

### PUBLIC HEALTH CONDITIONS IN GERMANY ARE GOOD

General of the Army, Dwight D. Eisenhower, in a report to the United States joint Chiefs of Staff, dated 20 August 1945, said that in general the health conditions of the civilian population in Germany are good.

Due to damaged water and sewage systems, some local epidemics of dysentery and typhoid fever have occurred, although typhus incidence has declined. Loss in body weight has resulted from the low general level of food consumption. The average daily diet for normal adults is estimated at between 1,150 and 1,730 calories. Displaced persons have been receiving a minimum of 2,000 calories.

### UNRRA'S TYPHOID IMMUNIZATION OF DISPLACED PERSONS

UNRRA has procured two million doses of typhus vaccine from the United States Typhus Commission for immunization of Displaced Persons in the United States occupation zone of Germany, according to word received at UNRRA's Washington headquarters from Lieutenant Colonel David C. Elliot, of Cincinnati, U. S. Public Health Officer and UNRRA Chief Medical Officer for the zone.

Delivery of an extra one million doses is expected soon which, with stocks now on hand, will provide enough vaccine for a series of three typhus innoculations to one million D.P.'s. There are 639,000 D.P.'s remaining in the United States zone, with added numbers expected to enter assembly centers during the winter.

Innoculation of children against diphtheria already has begun and will be completed by mid-November. Enough material to innoculate 35,000 to 45,000 children has been drawn from German and American sources. Stocks sufficient to innoculate 50,000 additional D. P. children have been requested from American sources. Adequate supplies of smallpox vaccine and typhoid vaccine are on hand, and are being administered now by assembly center team doctors.

# WORK OF MEDICAL DEPARTMENT IN WORLD WAR II

In his Biennial Report to The Secretary of War, General George C. Marshall, Chief of Staff of the United States Army, paid tribute to the Medical Department for its outstanding work in World War II, as follows:

"The remarkable reduction in the percentage of the deaths from battle wounds is one of the most direct and startling evidences of the great work of the Army medical service. In the last two years Army hospitals treated 9,000,000 patients; another 2,000,000 were treated in quarters, and more than 80,000,000 cases passed through the dispensaries and received outpatient treatment. This tremendous task was accomplished by 45,000 Army doctors, assisted by a like number of nurses and by more than one-half million enlisted men, including battalion-aid men, whose courage and devotion to duty under fire has been as great as that of the fighting men they assisted.

"One of the great achievements of the Medical Department was the development of penicillin therapy, which has already saved the lives of thousands. Two years ago penicillin, because of an extraordinarily complicated manufacturing process, was so scarce the small amounts available were priceless. Since then mass production techniques have been developed and the Army is now using 2,000,000 ampules a month.

"Despite the fact that United States troops lived and fought in some of the most disease-infested areas of the world, the death rate from non-battle causes in the Army in the last two years was approximately that of the corresponding age group in civilian life—about 3 per 1,000 per year. The greater exposure of troops was counter-balanced by the general immunization from such diseases as typhoid, typhus, cholera, tetanus, smallpox, and yellow fever, and, obviously, by the fact that men in the Army were selected for their physical fitness.

"The comparison of the non-battle death rate in this and other wars is impressive. During the Mexican War, 10 per cent of officers and enlisted men died each year of disease; the rate was reduced to 7.2 per cent of Union troops in the Civil War; to 1.6 per cent in the Spanish War and the Philippine Insurrection; to 1.3 per cent in World War I; and to 0.6 per cent of the troops in this war.

"Insect-borne diseases had a great influence on the course of operations throughout military history. Our campaigns on the remote Pacific Islands would have been far more difficult than they were except for the most rigid sanitary discipline and the development of highly effective insecticides and repellents. The most powerful weapon against disease-bearing lice, mosquitoes, flies, fleas and other insects was a new chemical compound commonly known as DDT. In December, 1943, and early 1944, a serious typhus epidemic developed in Naples. The incidence had reached fifty cases a day. DDT dusting stations were set up, and by March more than a million and a quarter persons had been processed through them. These measures and an extensive vaccination program brought the epidemic under control within a month. Shortly after the invasion of Saipan an epidemic of dengue fever developed among the troops. After extensive aerial spraying of DDT in mosquito-breeding areas, the number of new cases a day fell more than 80 per cent in two weeks. The danger of scrub typhus in the Pacific Islands and in Burma and China was reduced measurably by the impregnation of clothing with dimethyl phthalate.

"The treatment of battle neurosis progressed steadily, so that between 40 and 60 per cent of men who broke down in battle returned to combat, and another 20 to 30 per cent returned to limited duties. In the early stages of the war less than 10 per cent of these men were reclaimed for any duty.

"The development of methods of handling whole blood on the battlefield was a great contribution to battle surgery. Although very useful, plasma is not nearly as effective in combating shock and preparing wounded for surgery as whole blood. Blood banks were established in every theatre, and additional quantities were shipped by air from the United States, as a result of the contribution of thousands of patriotic Americans. An expendable refrigerator was developed to preserve blood in the advanced surgical stations for a period of usefulness of twenty-one days.

"So that no casualty is discharged from the Army until he has received full benefit of the finest hospital care this nation can provide, the medical service has established a reconditioning program. Its purpose is to restore to fullest possible physical and mental health any soldier who has been wounded or fallen ill in the service of his country.

"To insure that men are properly prepared for return to civilian life the Army established twenty-five special convalescent centers. At these centers men receive not only highly-specialized medical treatment, but have full opportunity to select any vocational training or recreational activity, or both, they may desire. Men who have been disabled by loss of arms or legs, for example, are fitted with artificial limbs and taught to use them skillfully in their former civilian occupation, or any new one they may select. Extreme care is taken to insure that men suffering from mental and nervous disorders resulting from combat are not returned to civilian life until they have been given every possible treatment and regained their psychological balance."

# Military News

## MAJOR NELSON N. KAUFFMAN RETURNS FOLLOWING RELEASE FROM JAPANESE PRISON

The safe return of one of our Indiana physicians, Major Nelson N. Kauffman, of Indianapolis, who survived three and one-half years of internment as a prisoner of the Japs is, indeed, a long-awaited message which touches the hearts of all who knew Major Kauffman prior to his entry in the Army Medical Corps.

*It was a happy reunion when Major Nelson N. Knuffman (left) who had been a prisoner of the Japs since the fnll of Bataan, was greeted by his brother, Captain Sidney A. Kauffman, who recently returned from a thirty-nine-month service in the European Theatre of Operations.*

He graduated from the Indiana University School of Medicine in 1938, and was a resident at the Indianapolis City Hospital at the time he entered the Army in October, 1940.

Major Kauffman was sent to the Philippines in January, 1941, where he was stationed at the Post of Manila until shortly before the war, when he was assigned to the 31st Infantry, serving as a surgeon with the 1st Battalion. This battalion remained in Manila until almost everyone else was evacuated, and then went with General MacArthur to Corregidor, where they occupied topside barracks until after the first intensive bombing of Corregidor forced the evacuation of the barracks, when they were shipped to Bataan, and where they went into the line. Later they joined the other two battalions on Bataan. At times the battalions fought separately, and at other times as a whole unified regiment, until the fall of Bataan on April 9, 1942.

After Major Kauffman became a prisoner he worked in Base Hospital No. 2, where efforts were made to get our patients well enough so that they could be moved out of the peninsula of Bataan before the rainy season began, which was impending at that time.

About June 1, 1942, he was sent to Cabanatuan after spending about ten days in Bilibid en route. The prisoner-of-war camp at Cabanatuan eventually contained seven thousand American troops and officers, two thousand of whom were allowed by the Japanese to be considered hospital patients. These were merely the sickest of the seven thousand men. Major Kauffman took care of two of the dysentery wards until October 8, 1942, when he was sent to Japan with two thousand prisoners. After a thirty-six-day journey on a very small and inadequate boat, they landed in Formosa, later in Korea, and finally arrived in Kobe, where Major Kauffman was taken by train to Yokohama, and placed in a camp with about five hundred men—Americans, British, and a few Australians, remaining there for about two years. From that time until the end of the war he was moved in and out of seven different camps, sometimes for medical benefit, and sometimes for discipline, actually spending five months in concentration camps for punitive reasons during this period. All of these camps were in or around the Tokyo-Yokohama district.

On July 2, 1945, Major Kauffman, together with seventy other Americans, were sent farther north, on the east coast of Honshu, to Hitachi, where they stayed just long enough to see the whole place bombed, burned, and shelled. The city was completely demolished, much like that already suffered by the greater part of Yokohama and Tokyo. On July 28, 1945, Major Kauffman was sent to another prisoner-of-war camp in Niigata, where he remained until the war ended.

The first indication the prisoners had that the war was coming to a close occurred on August fourteenth, when B-29's dropped pamphlets, written in Japanese, which were surreptitiously translated by some of the prisoners as the Potsdam Declaration. Shortly thereafter they noted that the Emperor made a speech, during which every Jap stood at rigid attention, and about August nineteenth a Jap confidant intimated that it might be a truce.

Then came the happy day, September fourth, when Major Kauffman together with the other prisoners at his camp were liberated by Commander Harold Stassen (who flew in on September second and made the arrangements for the prisoners' rescue), and they were taken by train to Yokohama, where they were placed on board an American hospital ship (no occupation troops having as yet arrived in Japan), examined and

flown by plane to Okinawa. A week later Major Kauffman was taken to Manila, where he boarded a ship for San Francisco, completing the trip to Stout Field, Indianapolis, via airplane.

Throughout his internment Major Kauffman continued insofar as possible to aid the sick, injured, and dying, even at the expense of being punished therefor, and the highest praise has come from other prisoners who believe that it was through his ministrations that many lives were saved.

On asking Major Kauffman what possible source of solace he derived throughout those many months of confinement in Jap prison camps, he replied that as a physician his greatest sense of pride was the fact that he had received his training in a medical school which qualified its graduates in such a way as to make them not only physicians, but "men among men." And as further proof of the inspiration he derived from his esteem for his home state, he concluded by saying, "then on arriving home and being welcomed so warmly and enthusiastically by people who showed sincere regard for my welfare, that more or less crystallized the idea that Indiana is 'God's country.' "

Major Kauffman wears the Pre-Pearl Harbor ribbon, with one battle star; the Asiatic-Pacific Theatre ribbon, with two battle stars; the Philippine Defense ribbon, with one battle star; the Combat Infantry Medical Badge; and the Presidential Unit Citation, with two Oak Leaf Clusters.

*Indiana salutes Major Kauffman!*

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When Major Nelson N. Kauffman came to our office he was accompanied by his brother, Captain Sidney A. Kauffman, who had been in practice in Indianapolis from September, 1939, to January, 1941, but who had also been overseas for thirty-nine months.

Since Captain Kauffman was wearing many service stripes, the Pre-Pearl Harbor ribbon, and the European Theatre of Operations ribbon with five battle stars, we prevailed upon him to tell us some of his experiences.

Captain Kauffman was called to active duty on January 12, 1941, as a reserve officer, and for the first fourteen months was stationed with the 8th Infantry Division, at Fort Jackson, South Carolina. He was then transferred to the newly-activated 3rd Station Hospital, at Camp Blanding, Florida, where the members of his unit were trained for overseas duty. Landing in England the twelfth of July, 1942, they set up a hospital at Tidworth, where Captain Kauffman served as assistant chief of the medical service until July 1, 1944, when he was transferred to the 2nd General Hospital. This unit went into France on July 24, and set up a tent hospital in Normandy, where Captain Kauffman served as an assistant to the neurosurgeon.

In January, 1945, the hospital moved to Nancy, France, where Captain Kauffman did general surgery until the unit was deactivated in late August and sent to Marseilles for embarkation for the homeward journey.

He arrived at Camp Atterbury on September 28, after having been flown from Paris by ATC and was discharged from service on October second.

Captain Kauffman was in the Battle of Ardennes, being at that time on detached service with the 104th and 109th Evacuation Hospitals. He also spent May and June on detached service with the RAMP Hospital (Recovered Allied Military Personnel) near Leipzig, Germany.

He stated that his future plans are indefinite, but that he will eventually resume his practice in pediatrics.

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Dr. Joe W. Sovine, of Indianapolis, has been promoted to commander, and has been transferred from the United States Naval Hospital, at San Diego, to the Advance Base Personnel Depot, at San Bruno, California, in preparation for overseas' duty.

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Captain George R. Horton, of Indianapolis, is chief of the anesthesia and surgical section of the 23rd Station Hospital at Camp Crowder, Missouri. The hospital was redeployed from the European Theatre in July, and is now in training for duty in the Pacific area.

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Lieutenant Colonel Paul G. Iske, of Indianapolis, was with the 119th Station Hospital, in Finschafen, New Guinea, when the unit divided and half of its force was sent to Hollandia, where Colonel Iske is serving as its commanding officer. It is reported that Hollandia is mountainous and very scenic, but that it is too hot for comfort.

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Major Eugene W. Austin, of Anderson, was present at the arrival of the Japanese envoys at Ie Shima, where they were taken on board a transport plane for Manila. His group of heavy bombers were slated to be transferred from Ie Shima to Tokyo with the invasion troops. According to Major Austin, it appears that inflation has a good start in Manila—pie a la mode is $3.50, and all other prices are correspondingly high.

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Lieutenant Colonel Davis H. Sluss, of Indianapolis, is in command of the 179th General Hospital, which is located twenty-five miles south of Rheims, France, at Camp Philadelphia. The hospital was first operated in the old Hotel Dieu at Rouen, with a bed capacity of fifteen hundred, and was slated for direct redeployment, but with the end of the War, Colonel Sluss hopes ere long to be on his way to the good old U. S. A.

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Captain Jose A. Torrella, of Indianapolis, has been in Europe for two years. He spent thirteen months with the 304th Station Hospital, in England, and was awarded a Certificate of Merit, a Bronze Arrowhead, and battle stars for his part in the invasion of France. Captain Torrella is now based at Nancy, France, and is surgeon and executive officer of a hospital train connected with the

Fourth Hospital Train Unit, which has transported casualties over all of western Europe in the wake of the advancing armies.

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As squadron surgeon for a B-29 group, Captain Robert C. Peacock, of Indianapolis, is stationed at Victoria, Kansas.

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Captain Joseph R. Caton, of South Bend, has been transferred from Fort Bliss, Texas, to the Ashburn General Hospital, at McKinney, Texas.

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Captain Harold T. Moore, of Indianapolis, is stationed at the Army Air Base, at Salinas, California.

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Captain Robert M. Lohman, of Fort Wayne, is now at Camp Chaffee, Arkansas, after being transferred there from Camp Gruber, Oklahoma.

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After spending a thirty-day leave in Peru, Captain Robert Horton has returned to the 23rd Station Hospital at Camp Crowder, Missouri.

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Dr. Cecil L. Andrews, of Greenfield, who was formerly stationed aboard the *U.S.S. Dakota*, is now at the United States Naval Hospital, in Bethesda, Maryland.

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After being stationed overseas, Major John W. Little, of Indianapolis, has returned to this country, and is stationed with the 122nd Evacuation Hospital, at Camp Gruber, Oklahoma.

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Formerly at the Station Hospital, at Camp Howze, Texas, Major Leonard C. Lund, of Argos, is now at the Glennan General Hospital, at Okmulgee, Oklahoma.

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A former Acton physician, Dr. Norval C. Folkening, has been transferred from the Marine Hospital at Staten Island, New York, to the Marine Hospital at Buffalo, New York.

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Now on duty with the 156th General Hospital at Camp Crowder, Missouri, Lieutenant Richard H. Gwartney, of Muncie, was formerly stationed at Fort Sheridan, Illinois.

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Now stationed on Okinawa, Captain Gilbert J. Himebaugh, of Indianapolis, is serving as battalion surgeon with an ordnance ammunition battalion.

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Lieutenant Lewis G. Jacobs, of Indianapolis, is doing radiation therapy and diagnostic radiology at the Ashburn General Hospital, McKinney, Texas, which is an arthritic center.

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Dr. Albert F. Clements, of Evansville, has been promoted to the rank of full commander. He has been in the Navy for three years. After a tour of duty on the *U.S.S. Solace*, hospital ship, Commander Clements is now at a Navy Hospital on Long Island.

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Lieutenant Myron H. Nourse, of Indianapolis, is now on duty at the United States Naval Hospital, at Oceanside, California.

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Major Carl J. Rudolph spent part of July and August in South Bend, after returning home from overseas.

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Major Joseph O. Flora, of Indianapolis, is chief of medicine with the 172nd Evacuation Hospital, at Fort Jackson, South Carolina.

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Captain Charles E. Moehlenkamp, of Evansville, has been transferred from Wakeman General Hospital to the Percy Jones Hospital Center, at Fort Custer, Michigan.

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Lieutenant Commander Louis T. Need, of Indianapolis, is stationed at the United States Naval Hospital, at Newport, Rhode Island, and is doing psychiatric work.

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Captain Irving Weissman, of Fort Wayne, is now stationed at Camp Bowie, Texas. He recently returned from overseas duty with the 126th Evacuation Hospital.

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On duty as the senior medical officer for Navy recruiting in Indiana, Dr. Byron K. Rust, of Indianapolis, has been promoted to the rank of commander.

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Assigned to the Army and Navy General Hospital at Hot Springs, Arkansas, Lieutenant Edward John Ettl, of Indianapolis, is ward officer for all poliomyelitis patients in the institution.

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Formerly the chief of surgery at the Valley Forge General Hospital, at Phoenixville, Pennsylvania, Colonel John E. Owen, of Indianapolis, left this country on July first, and is now the commanding officer of a general hospital in India.

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Major Walter D. Close, of Indianapolis, has been home on a thirty-day leave. Formerly on duty with the 92nd Station Hospital, in Iceland, Major Close reports that although the country is quite barren, and there is not much of interest, the hospitals are well-equipped and quite modern.

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It has been announced that Dr. Russell A. Flack, of Lafayette, has been promoted to commander. Since entering the Navy, he has served at Washington, D. C., at Coco Solo in the Canal Zone, and at the Bunker Hill Naval Air Station. Commander Flack has been home on a short leave, but has now returned to his present station at the United States Naval Hospital, at Memphis, Tennessee.

Formerly stationed with the 289th Station Hospital overseas, Captain Paul E. Dingle, of Richmond, is now at Fort Benjamin Harrison, Indiana.

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Formerly at Sioux Falls, South Dakota, Captain Harold G. Petitjean is now at Hammer Field, Fresno, California.

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The Office of the Surgeon General has announced that Dr. C. P. McLaughlin, of Pendleton, has been promoted from major to lieutenant colonel.

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We have learned that Dr. R. W. Gehres, of Shelbyville, has been promoted to commander. He is now stationed at the Navy Yards at Charleston, South Carolina. Commander Gehres entered the service in August, 1942, and served on sea duty for sixteen months.

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Announcement has been made of the promotion of Dr. Pierce MacKenzie, of Evansville, from commander to captain. Captain MacKenzie was called to active service in April, 1941, and saw action on Guadalcanal. He is now on his second tour of sea duty, having been in the Pacific for the last two months.

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Major Aaron L. Arnold, of Indianapolis, has been stationed since January at Camp Atterbury as medical inspector, in addition to doing dispensary work. Prior to that time he was stationed in New Guinea as chief of the Communicable Disease Section of the 49th General Hospital.

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The Bronze Star has been awarded to Major David Hadley, of Indianapolis, for meritorious service in combat in the European Theatre during the period between December 7, 1944, and May 9, 1945. Major Hadley saw action in France, Belgium, Luxembourg, and Germany as division surgeon with the 87th Division Artillery. He is still on duty with the division, which has returned to Fort Benning, Georgia.

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With the Seventh Emergency Rescue Squadron in India since last April, Captain Francis G. Sheehan, of Indianapolis, was supposed to have been doing parachute medical work in the China and Burma jungle, but it turned out that all of the squadron's missions have been for the rescue of fighter crews in the Bay of Bengal. For this work they used either Catalina flying boats or B-17's with a life-boat attached to the bomb bay for dropping when the sea was too rough to land the Catalina flying boats. Captain Sheehan is now on Okinawa with the Eighth Air Force, and is hoping to return home soon.

Captain Victor F. Albright, of Indianapolis, writes that his job is now practically non-existent—no illness and no injuries. He is stationed in Augsburg, Germany, with the 323rd Bomb Group. He has been overseas twenty-eight months.

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Lieutenant Norman R. Cook, of Indianapolis, who has been with the Mason General Hospital, at Long Island, New York, for about two and one-half months, has been home on a terminal leave, and has joined the 159th General Hospital, at Camp Crowder, Missouri.

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Lieutenant Clifford E. Ernst, of Indianapolis, is on duty as a medical officer aboard the *U.S.S. Tasker H. Bliss*, a troop transport. He states that aboard ship they have a very well-equipped hospital with excellent laboratory facilities.

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Major Ivan W. Scott, of Indianapolis, who has been stationed at the Walter Reed General Hospital, in Washington, D.C., after many months of duty in India, has now been transferred to duty in the Pacific aboard a hospital ship, the *Emily H. M. Weder*.

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As an air evacuation flight surgeon, Captain Roderick L. Boling, of Indianapolis, has been based in various places in the Pacific. He states that they evacuated Captain David McKinley, also of Indianapolis, from Saipan, and saw him later on Okinawa. (Captain McKinley was seriously injured while on Saipan, but is now fully recovered and about to become a civilian again.)

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Captain Joseph T. Farrell, of Indianapolis, is in command of the field unit hospital (set up by the First Cavalry Division, and the first to get in operation in the Tokyo area) where General Hideki Tojo's life was saved following his essayed harakiri. He has reported that Tojo's faulty aim prevented his 'rendezvous with his honorable ancestors.' The bullet plowed through the left breast, missing the heart by one inch. They sewed up the wound, administered plasma, and sent Tojo to the 98th Evacuation Hospital at Yokohama, where he is reported to be doing nicely, according to Leo M. Litz, *Indianapolis News* War Correspondent. He further reported that the ambulance which was used in bringing Tojo to the hospital has been captioned "Tojo's Hearse," and that the boys have painted a caricature of Tojo on the side of the vehicle, hoping to exhibit the ambulance in a parade. Captain Farrell, who joined the outfit in Australia, and has been with it through all campaigns, is eagerly awaiting the day when he can make his home *his* rendezvous.

(Since the above was typeset Captain Farrell has returned to Indianapolis.)

Colonel Arthur N. Ferguson, of Fort Wayne, is now chief of medical service at the Foster General Hospital, at Jackson, Mississippi. Colonel Ferguson was formerly at the Oliver General Hospital, Augusta, Georgia.

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Major Joseph E. Ball, an intern at the Indianapolis City Hospital prior to his entry into service, recently spent a few days in Indianapolis. Major Ball spent thirty-two months in the South Pacific as group surgeon for a service group. He has been attending a refresher course at Randolph Field, Texas, since his return to this country, and is now at Chanute Field, Illinois.

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"I have been up in the Philippines, and am now on duty here in the Admiralty Islands," writes Commander J. H. Stamper, of Middletown. "We have an excellent naval base here. Recently, I was promoted to the rank of commander, and at my 'wetting-down' party were Captain J. R. Phillips, of Michigan City, and Commander R. G. Gilbert, of Rome. I have recently seen Commander John C. Drake, of Anderson. Hoosiers are quite thick out here, and all are anxious to get back to Indiana."

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A Citation for Meritorious Achievement has been received by Lieutenant Colonel Harry M. Covell, of Auburn, for service in connection with military operations against the Japanese on Leyte and Okinawa. As division surgeon, Colonel Covell not only prepared the division plans for medical service, but directed the operation of medical services and coordinated their work with the hospital. The citation further stated, "Lieutenant Colonel Covell's untiring efforts and the high caliber of his services under extremely difficult conditions were assets of major value to the division, and reflect great credit upon himself and the military service." Colonel Covell has been in the service for fifty-six months, and has been overseas since July, 1944.

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Captain Charles F. Gillespie, of Indianapolis, is on duty with the 116th Evacuation Hospital, which began operation on November 30, 1944, and received more than 15,000 patients in three months, 6,500 of whom were surgical cases. In a letter to the *Indianapolis Medical Society Bulletin*, he wrote:

"'During combat we called it "cafeteria surgery" because an evacuation hospital does surgery continuously night and day, and even then we might have more than a hundred freshly-wounded cases waiting. When the push really started, we would move about every eight or twelve days, making jumps of one hundred miles or more. In May we were in the Dachau Concentration Camp, where we took care of more than two thousand typhus cases. June and July we spent in one of Germany's "health cities," Bad Mergentheim. We had a swell hospital building there, instead of tents.'"

The Bronze Star has been awarded to Captain Edward B. Boyer, of Indianapolis, for heroism in the taking of Peleliu Island. The citation accompanying the award declared that while on duty as assistant regimental surgeon with the 81st Division, Captain Boyer "observed a wounded man lying in an exposed area, advanced to his side under enemy fire, administered first aid, and carried him to a position of safety." The citation also stated that the action "probably saved the man's life, and inspired all who observed it."

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Dr. J. P. Worley, of Indianapolis, received his promotion from captain to major in May of this year. Major Worley has been overseas since April, 1944. He was first a surgeon with Merrill's Marauders, and fought in the last campaign with the Mars Task Force. In Burma, Major Worley received two bronze combat stars, the Presidential Unit Citation, Combat Medical Badge, and the Purple Heart. He was wounded when his outfit was opening the Burma Road against the Japs. Later he was cited for outstanding bravery and awarded the Silver Star.

In April of this year, after his outfit had fought behind enemy lines and walked five hundred and sixty miles through the jungles and over the mountains, they were flown into China. Major Worley was used at first as a medical trouble shooter, and was flown into the front lines for medical emergencies. Here he received two more bronze combat stars. For the past two months he has been Third Army Group Surgeon on General Bayes' Special Staff.

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Doctor Robert W. Kuhn, of Wilkinson, who was resident surgeon at the Indianapolis City Hospital when he enlisted in the armed forces in April, 1942, has recently been promoted from major to lieutenant colonel. After training at Fort Lewis, Washington, Colonel Kuhn was immediately sent to England, and when the American troops drove the Germans out of France he was attached to the 178th General Hospital Unit, which was being organized at that time. He is now assistant chief of surgery for this unit.

In August, 1944, the 178th took over the American Memorial Hospital at Rheims, France, after the Germans, who had taken it from the French, were driven out.

The 2,250-bed hospital, one of the finest and most modern on the Continent, was founded by an American, Dr. Marie Louise LeFort, of New Jersey, and was used as a hospital for the orphan children of World War I. The staff consists of 72 medical officers, 125 American nurses, 650 trained enlisted specialists and five American Red Cross workers. During the first twenty-four hours of operation in December, 1944, the hospital admitted 1,194 Americans, many of them wounded in the Battle of the Bulge.

# News Notes

Dr. John E. Fisher has located in Attica and has begun the practice of medicine there. He practiced in Clarksburg for six years before entering the United States Army in May, 1942. He spent twenty-six months overseas.

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Dr. William R. Tindall, of Shelbyville, has been given a medical discharge from the Medical Corps of the United States Naval Reserve. He entered the Navy in September, 1942, and served as medical officer aboard the *USS Hammondsport* in the Southwest Pacific for two years.

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### THIRTEENTH COUNCILOR DISTRICT MEETING

A meeting of the Thirteenth Councilor District will be held at South Bend, on November fourteenth.

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Now on terminal leave, Dr. M. M. Crum, of Angola, served for nearly three years in the Army Air Forces as flight surgeon, on duty with the Troop Carrier Command. Captain Crum has the Presidential Unit Citation for the Normandy invasion, and wears seven battle stars. He has returned to Angola for the practice of medicine.

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Dr. D. Lee Andrews, who operated a private hospital in Clermont before entering military service, is now in practice in Louisville. He was released from service about a year and a half ago. Doctor Andrews has maintained his membership in the Indiana State Medical Association.

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After more than four years in the Army, Captain Raymond N. Adler, has returned to Evansville to resume his medical practice. Captain Adler served as a surgeon aboard a transport in the North Pacific Theatre. He wears a bronze star for the Battle of Dutch Harbor, Alaska.

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Captain Charles J. Aucreman, of Montpelier, has been relieved of active duty in the Army Air Force, and has been placed on inactive status. Captain Aucreman was in the service for fifty-five months, almost two years of which time was spent in the Pacific area. He was last stationed at Punta Gorda, Florida.

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### CHICAGO MEDICAL SOCIETY CONFERENCE

The Chicago Medical Society will hold its Annual Clinical Conference at the Palmer House, Chicago, Illinois, on March 5, 6, 7, and 8, 1946. All physicians are invited to attend this Conference and hear outstanding specialists from all sections of the country discuss subjects of major interest.

### AMERICAN COLLEGE OF PHYSICIANS' REGIONAL MEETING

A regional meeting of the American College of Physicians will be held in Chicago on November 10, 1945, with headquarters at Hotel Continental, 505 North Michigan Avenue. This meeting will be conducted by the American College of Physician Governors for Illinois, Indiana, Iowa, Kentucky, Michigan, Minnesota, and Wisconsin. Dr. Robert M. Moore, of Indianapolis, is the Indiana Governor.

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After a flight from Paris, Captain O. L. Siewert, of Logansport, was released from the Army on October seventh. Doctor Siewert was with the 32nd General Hospital in Europe for two years, and wears four battle stars on his ETO ribbon.

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Formerly of Muncie, Dr. Charles B. Kern has been named as resident physician at the newly-completed state hospital at Evansville.

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On October twenty-sixth it was announced by the Board of Directors, that Dr. Otho R. Lynch, a member of the staff of the Muscatatuck State School, at Butlerville, had been appointed as medical superintendent of the Richmond State Hospital. Doctor Lynch will succeed Dr. Paul D. Williams, whose resignation becomes effective November fifteenth.

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Captain James G. Shanklin, of Hammond, was discharged from service on October fourteenth. He had served in São Luiz, Brazil, during the past year; prior to that time he served as flight surgeon at Texas air fields.

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### INTERNATIONAL COLLEGE OF SURGEONS' MEETING

The International College of Surgeons will hold its Tenth Annual Convention and Convocation on December 7 and 8, 1945, at the Mayflower Hotel, Washington, D.C. At this time approximately two hundred men will receive their Fellowship. A scientific program is arranged for both days. Convocation exercises will be held Friday evening, December 7, in the Mayflower Auditorium.

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Dr. William B. Challman, of Mount Vernon, has received a discharge, and has returned to Mount Vernon. Prior to his return to this country, several months ago, he was stationed in the China-Burma-India Theatre with the Twentieth Air Force. Doctor Challman held the rank of major.

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Another Mount Vernon physician who has returned from service is Dr. Frank W. Oliphant, who had been overseas for thirty-two of the thirty-nine months he spent in the Army. Doctor Oliphant held the rank of captain, and participated in the

entire Italian campaign. It has been announced that Doctor Oliphant has been named as jail and infirmary physician by Posey County commissioners, and will succeed Dr. J. R. Ranes, who served in his absence.

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For the past twenty-one months Dr. Robert S. McElroy, of Princeton, has served as a major with the 97th Evacuation Hospital, in France. He recently returned from Paris, and was discharged at Camp Atterbury on September twenty-sixth. It is reported that he will reopen his office in the near future.

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In order to accept a position as resident urologist at the Presbyterian Hospital in Chicago, Dr. John I. Waller has closed his office in Knightstown. Part of his time will be spent as a member of the staff of the University of Illinois College of Medicine.

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Dr. Kenneth E. Comer, of Mooresville, has been discharged from the United States Army after three and one-half years of service. Dr. Comer spent twenty-six months in the European Theatre as flight surgeon with the Eighth Air Force. It has been announced that he plans to resume his medical practice.

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Another Indiana physician "home from the wars" is Dr. Frank J. Kendrick, of Gary, who was called to service in December, 1940. On duty in the Atlantic, assigned to an Army transport, the longest period he was ever ashore during this time was four months spent at Casablanca. Doctor Kendrick will re-establish his practice in Gary.

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After thirty-seven months overseas' duty, Dr. Hugh S. Ramsey, of Bloomington, has resumed practice there. Doctor Ramsey served with the rank of captain in both field and base hospitals in France, and was in the service a total of four and one-half years.

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### CONFERENCE ON TUBERCULOSIS

A Conference on Control of Tuberculosis in a Metropolitan Area, sponsored by the Institute of Medicine of Chicago, will be held on Tuesday and Wednesday, November 13 and 14, 1945, at the Palmer House, Chicago. For further information and programs, address The Institute of Medicine of Chicago, Chicago 1, Illinois.

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We are informed that Dr. John L. Hillery, of Silver Lake, has received a discharge under the point system, after four and one-half years of Army service, two years of which were spent overseas. He held the rank of lieutenant colonel, and was on duty most of the time with the 65th Medical Regiment. He was with Patton's Third Army until just before the close of the war, when he went to Aachen. He was at Rheims, France, when the war ended. He has the Bronze Star Medal and five battle stars. At this time his future plans are indefinite.

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After two years' service overseas, in Casablanca and Italy, Captain Roy T. Hynes, of Indianapolis, has received a discharge and will return to practice in Indianapolis. He had been in the Army three and one-half years.

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After receiving his discharge from the Army on October third, Dr. William E. Pearson has returned to Wabash to resume his medical practice. Dr. Pearson was a captain with the 38th Division, and had served in various areas in the South Pacific, including the Battle of Luzon. He has been awarded the Bronze Star Medal.

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### PHYSICIAN-ARTISTS' PRIZE CONTEST

The American Physicians Art Association, with the cooperation of Mead Johnson & Company, is offering an important series of War (Savings) Bonds as prizes to physicians in the armed services and physicians in civilian practice for their best artistic works depicting the medical profession's "skill and courage and devotion beyond the call of duty."

For full details, write to the Association's Secretary, Dr. F. H. Redewill, Flood Building, San Francisco, California, or Mead Johnson & Co., Evansville 21, Indiana.

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On duty with the Army Medical Corps for thirty-seven months, Captain Robert H. Pierson, of Spencer, was first stationed at the LeGarde General Hospital, in New Orleans. He then went overseas as battalion surgeon with the 358th Engineers, with whom he remained until his return here on August eighteenth. The battalion was stationed for some time in England, going into Normandy on D-plus-3 Day. They went on through France, Belgium, and Holland. Doctor Pierson has been discharged, and is at Spencer at present, although his future plans are indefinite.

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On September 21, 1945, Commander E. Rogers Smith, of Indianapolis, was separated from military service, after more than three years' duty with the Navy. Commander Smith was first stationed for one year at Mare Island, California, going overseas from there in September, 1943, with the Naval Mobile Hospital No. 6, the largest neuropsychiatric hospital in the Navy. He was one of four neuropsychiatric officers chosen to form the nucleus of the hospital at Auckland, New Zealand, where he was stationed nine months. From there he went to Espiritu Santo, in the New Hebrides, where he also stayed nine months, going from there to the Fleet Hospital 105, in New Caledonia, where he served as chief of medicine. He was then returned to the United States where he was assigned to St. Elizabeth's Hospital in Washington. Commander Smith has resumed his practice in his former offices in the Hume Mansur Building.

Dr. Jack Dick has received a discharge from the Army Medical Corps, and has located in Rensselaer for the practice of medicine.

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After four years of service in the armed forces, Dr. Richard N. Washburn has returned to the Washburn-Johnson Clinic in Rensselaer. He held the rank of lieutenant colonel, and served overseas two years. He was with the 65th General Hospital.

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Dr. Helen B. Barnes, formerly of Clarksburg, has recently opened an office in Greenwood. Doctor Barnes will limit her practice to pediatrics.

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Captain Robert H. Williams, of Anderson, has been discharged from service at the Santa Ana Army Air Base, and has returned home. He was stationed in the European Theatre for thirteen months as head of a front-line hospital unit.

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Dr. A. M. Fichman, of Fort Wayne, has opened an office in New Haven for the practice of medicine, and will devote part of his time to practice there. He will also continue to maintain his office in Fort Wayne.

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As a flight surgeon with the Army Air Corps, Dr. Robert B. Smallwood has done much flying and has covered almost the entire Pacific. His headquarters were at Hickam Field, Hawaii, although he was based for about four months at Saipan. Doctor Smallwood has now been released, and has returned to practice at Bedford.

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### MEDICAL PERSONNEL NEEDED BY UNITED NATIONS RELIEF AND REHABILITATION ADMINISTRATION

The Chinese Government has requested UNRRA to provide, as soon as possible, some two hundred field personnel to strengthen the available Chinese personnel. They will be required to head the respective services in hospitals of one hundred or two hundred fifty beds, which will be established in areas recently liberated from the Japanese. The personnel needed are in the following categories: general surgeons; orthopedic surgeons; genito-urinary surgeons; gynecologists and obstetricians; general physicians; dermatologists and syphilologists; ophthalmologists; otolaryngologists; radiologists; dentists; pediatricians; laboratory technicians; x-ray technicians; sanitary engineers; public health engineers; public health nurses; and clinical nurses.

General practitioners with some specialist experience will be acceptable. Candidates should be under fifty-five years of age, and in good physical condition. Those interested, please write to Szeming Sze, M.D., Chief, Far Eastern Section Health Division, at UNRRA, 1344 Connecticut Avenue, N.W., Washington 25, D.C.

Now on terminal leave from the Surgeon General's Office, in Washington, D.C., Lieutenant Colonel Don J. Wolfram has returned to Indianapolis to resume private practice. He had been in the Army since December, 1940.

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C. B. Fausset, M.D., has returned to his former location at 408 Hume Mansur Building, Indianapolis, on separation from military service. His practice is limited to neurological surgery.

Doctor Fausset landed in England in April, 1944, and spent two months there. He was transferred to the Continent on June 26, landing on Utah Beach. From this time on he was in charge of a neurosurgical team with the Fourth Auxiliary Surgical Group, working for a month and a half with the First Army, and thereafter following the Third Army from Carentan across France to Metz. Durnig the "Belgian Bulge" he was stationed in Arlon, Belgium, later going to Luxembourg.

On a rotation plan, Doctor Fausset then was in charge of a neurosurgical center in England for two months, and rejoined his unit in Germany.

Following the European phase, his last duty station was in Pilsen, Czechoslovakia. He participated in five battle campaigns, including Normandy, Northern France, Ardennes, Rhineland, and Central Europe. He then flew from Pilson to Paris, and from Paris to the states, by C-54 Air Transport. He has completed his overseas' leave, and was separated from military service on October 23, 1945.

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On October eleventh, a seventeen-month-old baby girl was admitted to the Ball Memorial Hospital, under the care of Dr. G. H. Young, with a clinical diagnosis of tuberculous meningitis, which was later confirmed by laboratory examinations.

Doctor Young immediately began a nation-wide search for a supply of streptomycin, for the treatment of the case, and the interest of the family as well as the community was immediately aroused. This interest was further accentuated by the fact that this was the only child of a serviceman who was killed in a parachute jump behind the German lines during the invasion of France.

Great difficulty was encountered in obtaining a supply of the drug, but an appeal made directly to President Truman immediately elicited the personal attention of the President. Quantities of the drug came to Muncie from a number of sources, and as soon as treatment was instituted the patient began to show rapid improvement.

The outlook is admittedly very dark, but the improvement under the first week's treatment had been little short of miraculous. This case is one of very few in which streptomycin has been used in the treatment of tuberculous meningitis, and the final outcome will be awaited with the greatest interest by all who have heard of the case.

## INDIANA UNIVERSITY NEWS NOTES

Sixty-five graduates who received the Doctor of Medicine degree from the Indiana University School of Medicine in August are now serving their internships in Indiana, Dr. W. D. Gatch, dean of the Indiana University School of Medicine, has announced. The remaining thirty-five members of the class are interning in hospitals located in all parts of the United States.

The Indianapolis City Hospital, with seventeen young Indiana University doctors, has the largest group of interns from the August class. Fourteen are in the Indiana University Hospitals, thirteen in the Methodist Hospital, and seven in St. Vincent's Hospital, all of Indianapolis. Other Indiana internships are being served in hospitals in South Bend, Fort Wayne, Muncie, Lafayette, and Gary.

The newly-graduated Indiana University doctors at the Indianapolis City Hospital are as follows: William G. Bannon, Kokomo; Robert A. Beck, Terre Haute; Jesse F. Brown, Whiting; Thomas C. Brown, Sullivan; Paul V. Chivington, Jr., Indianapolis; Richard M. Craig, Fort Wayne; Robert W. Harger, Indianapolis; Paul S. Jarrett, Sharpsville; Wilbur L. Kenoyer, Connersville; Michael W. Manzie, Hoboken, New Jersey; Bill C. Martz, Anderson; George M. Murphy, Franklin; Paul W. Myers, Indianapolis; William C. Robertson, Indianapolis; William K. Saint, New Castle; Eugene E. Schmidt, Fort Wayne; and Donald A. Zalac, Indianapolis.

Those interning at the Indiana University Hospitals are: Fred S. Carter, Hammond; Tom H. Ebbinghouse, North Manchester; Dan W. Everett, Indianapolis; Craig W. Freeman, Anderson; Forrest W. Freeman, Anderson; Arthur K. Hamp, Kokomo; Paul D. Johnson, Jr., Terre Haute; Robert P. Knowles, Indianapolis; Melvin Matlin, Brooklyn, New York; John H. O. Mertz, Indianapolis; Eugene Newby, Sheridan; Richard B. O'Bryan, Columbus; Robert L. Raphael, Evansville; and Joseph S. Stratigos, South Bend.

At the Methodist Hospital, in Indianapolis, are the following Indiana University interns: Louis H. Blessinger, Huntingburg; Floyd B. Coleman, Martinsville; John Ellett, Jr., Coatesville; James L. Garrison, Lawrence; Howard T. Hammel, Monon; Ainslee A. Hood, Alexandria; William F. Kerrigan, Connersville; Joseph G. Klotz, Noblesville; George E. Paine, Elkhart; Joseph W. Sibbitt, Frankfort; Robert M. Squire, Lyons; Ben O. Stands, Lafontaine; and Ralph M. Steffy, Logansport.

St. Vincent's Hospital, in Indianapolis, has the following Indiana University interns: William W. Dalton, Clay City; Paul G. Donner, Columbus; Jordan H. Doran, Burket; Wayne H. Endicott, Indianapolis; Edwin S. McClain, Franklin; Eugene S. Rifner, Spiceland; and John E. Schreiner, Anderson.

Other Indiana hospitals having Indiana University interns are:

Epworth General Hospital, South Bend: R. Ross Fowler, Bloomington; Charles O. Hamilton, Selma; Robert J. Nichols, Knox; Donald R. Taylor, Wheeler; Lloyd S. Terry, Coatesville; William E. Van Fleit, Garrett.

St. Joseph's Hospital, Fort Wayne: Robert L. Haller, Fort Wayne.

Ball Memorial Hospital, Muncie: John H. Kneidel, New Castle; Harold B. Lehman, Berne; Edwin S. McClain, Franklin; Harold M. Manifold, Ingalls.

St. Elizabeth's Hospital, Lafayette: Robert H. Leak, Williamsport.

Lutheran Hospital, Fort Wayne: William J. Miller, Fort Wayne.

St. Mary Mercy Hospital, Gary: Dan Zavela, Indianapolis.

The remaining Indiana University medical school graduates are serving internships in the following hospitals: James A. Alford, Garrett, St. Barnabas Hospital, Minneapolis; Charles R. Alvey, Muncie, Marine Hospital, Baltimore, Maryland; Arthur M. Antonow, Terre Haute, Cook County Hospital, Chicago; Roy Ault, Jr., Terre Haute, Jersey City Medical Center; Harry W. Banker, Portland, St. Joseph Hospital, Fort Worth, Texas; Edwin N. Barnum, LaPorte, United States Naval Hospital, San Diego, California; Robert C. Bartlett, Bloomington, St. Luke's Hospital, Chicago, Illinois; Charles D. Benedict, Kanawha Valley Hospital, Charleston, West Virginia; Jack W. Clarke, Sacred Heart Hospital, Spokane, Washington; Vernon O. Erk, Memorial Hospital, Baltimore, Maryland; Verne K. Harvey, United States Naval Hospital, Great Lakes; George M. Haymond, North Manchester, Mt. Carmel Mercy Hospital, Detroit, Michigan; Mrs. Phyllis Gill Hillsamer, Bloomington, Jersey City Medical Center; Thomas A. Koons, Binghamton (New York) City Hospital; Charles A. Labotka, Staten Island (New York) Hospital; James F. Land, Kokomo, Youngstown (Ohio) Hospital; Leonard M. Lasser, Gary, Mount Sinai Hospital, Chicago, Illinois; Forrest C. Leiter, Rochester, Evangelical Hospital, Chicago; Joseph J. Littell, Indianapolis, Philadelphia General Hospital; William J. Little, Bicknell, St. Francis Hospital, Peoria, Illinois; Leon M. Liverett, Sibley Memorial Hospital, Washington, D. C.; John E. Meihaus, Indianapolis, United States Naval Hospital, Norman, Oklahoma; John M. Miller, Indianapolis, Henry Ford Hospital, Detroit, Michigan; James F. Peck, Princeton, United States Marine Hospital, Norfolk, Virginia; Thomas A. Petty, South Bend, William J. Seymour Hospital, Eloise, Michigan; Glen A. Ramsdell, LaPorte, Binghamton City Hospital, Binghamton, New York; Jordan C. Ringenberg, Woodburn, William J. Seymour Hospital, Eloise, Michigan; Bertram S. Roth, Muncie, St. Louis (Missouri) City Hospital; Marshall J. Rowdabaugh, Warsaw, Scoa-White Hospital, Temple, Texas; Joseph V. Schetgen, New Castle, Santa Monica Hospital, Santa Monica, California; Donald M. Schlegel, Brazil, Wisconsin General Hospital, Madison; Karl Stillwater, Detroit, Michigan; Jersey City Medical Center; James M. Wagoner, Huntingburg, Binghampton (New York) City Hospital; William A. Walter, Jr., Gary, St. Annes Hospital, Chicago, Illinois; John D Wilson, Evansville, United States Naval Hospital, San Diego, California.

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## MOST OF PACIFIC CASUALTIES TO BE HOME BY CHRISTMAS

Most of the three thousand battle casualties still remaining in the Pacific will be returned to the United States within sixty days, and all other transportable casualties are expected to be home by Christmas, according to a recent announcement by the War Department.

Some Army hospital ships are being shifted from the Atlantic to help speed up the transportation of sick and wounded from the Pacific area, increasing the present total of Pacific-operating hospital ships to twelve. However, a number of ships are to be kept in the Atlantic to meet the needs of occupation forces.

# Deaths

**William S. Ankenbrock, M.D.,** of Indianapolis, died suddenly in his office on September twenty-eighth, at the age of forty-nine. Doctor Ankenbrock graduated from the Indiana University School of Medicine in 1924. He has been a practicing physician in Indianapolis for twenty-five years. He was a member of the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**William A. Spencer, M.D.,** of Wolcott, died suddenly at his home on October third. He was seventy-three years of age. Doctor Spencer graduated from the Michigan College of Medicine and Surgery, Detroit, in 1901, and had been practicing in Wolcott since 1902. He was a member of the Miami County Medical Society, the Indiana State Medical Association, and a Fellow of the American Medical Association.

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**Milton E. Leckrone, M.D.,** of Rochester, died on October first, at his home, after a short illness. He was forty-five years of age. Doctor Leckrone graduated from the Indiana University School of Medicine in 1925, and had been a practicing surgeon in Rochester since 1928. He was a member of the American College of Surgeons and had specialized in surgery. He was a member of the Fulton County Medical Society, the Indiana State Medical Association, and the American Medical Association.

**Charles W. Denny, M.D.,** of North Madison, died on September twenty-sixth. He was seventy-seven years of age. Doctor Denny was a graduate of the University of Louisville School of Medicine, was a member of the Jefferson County Medical Society, an honorary member of the Indiana State Medical Association, and a member of the American Medical Association.

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**Anthony J. Schneider, M.D.,** of Indianapolis, was killed instantly on October ninth, when his automobile was struck by a passenger train. He was seventy years of age, and had been a practicing physician in Indianapolis for forty-seven years. Doctor Schneider graduated from the Medical College of Indiana, Indianapolis, in 1898. He was a member of the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and a Fellow of the American Medical Association.

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**John W. Webb, M.D.,** of Indianapolis, died suddenly in his office on October ninth. He was sixty-five years of age. Doctor Webb graduated from the Chicago Homeopathic Medical College, in 1904. He had limited his practice to otorhinolaryngology. He was a member of the Indianapolis (Marion County) Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association. He was also a member of the Indiana State Board of Medical Registration.

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## TWENTY-SEVEN HUNDRED DOCTORS RELEASED DURING SEPTEMBER

"During September and the first four days of October, the Army Medical Department has separated 2,700 doctors from the service, and by Christmas it is expected that 14,000 doctors will have been separated," Brigadier General Raymond W. Bliss, Acting Surgeon General of the Army, stated recently before the House Military Affairs Committee. Through the months of July and August approximately 1,300 doctors were released.

General Bliss pointed out that in proportion to the Army's 45,000 doctors on VE-Day, there are now 43,000 in service, 2,000 of whom are recent graduates of medical schools. With the high hospital load in this country, a large number of doctors are needed to staff hospitals and separation centers, which are now at peak operation. These centers require a total of 2,000 doctors.

Stating the approximate total of patients still in Army hospitals to be 400,000, General Bliss concluded, "You cannot treat patients without doctors. . . . According to the laws of Congress you cannot separate men without doctors. . . . By Christmas we will have reduced the number of doctors by at least 14,000, which represents more than 30 per cent of the total corps. At the same time, we will continue to meet our first and foremost responsibility, to give the American soldier the best medical care that any soldier in any Army has ever received."

# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION
### BUREAU OF PUBLICITY

September 10, 1945.

Present: H. G. Hamer, M.D., chairman; Ben B. Moore, M.D., and Ray E. Smith, assistant executive secretary and secretary of the Bureau.

The following news releases for the "Hints on Health" column, going to weekly newspapers, were approved:

Week of September 17, 1945—"School-Room Diseases."

Week of September 24, 1945—"The House We Live In."

Week of October 1, 1945—"Five Dollars for a Boil."

The secretary of the bureau reported that there is now a total of eighty-four papers getting the "Hints on Health" releases. It was decided to include *The Farmers Guide* on the mailing list. Copies of papers containing the columns were surveyed.

The bureau secretary reported that a speaker had been supplied the Howard County Medical Society, on September 7, 1945.

A letter from the chairman of the Committee on Necrology and History, recommending storage of the association's records (now at the Indiana University Medical Center) in the state library, was read. The bureau approved, and directed the secretary to check the records and propose a method of preparing them for storage.

The bureau approved a letter to be sent to county secretaries, announcing that the Committee on Mental Health had a list of speakers available for public meetings.

An educational program of the Oklahoma State Medical Association was reviewed, and the secretary was directed to write a letter to the Oklahoma Association, complimenting it for its splendid activities.

Offer of films on "Nursing," from the United States Office of Education, was considered and filed.

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## LOCAL SOCIETY REPORTS

**Elkhart County Medical Society** members met on October fourth, at Hotel Elkhart, Elkhart. The guest speaker was Dr. Austin E. Smith, of the American Medical Association, who discussed "Trends in Medical Progress." Forty-five members were present.


PROFESSIONAL PROTECTION

*DOCTORS DISCHARGED*

**from Military Service should notify Company immediately.**

*MILITARY POLICY*

**does not cover Civilian Practice.**

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GYNECOLOGY—Two Weeks Intensive Course on dates to be announced after January 1st.

OBSTETRICS—Two Weeks Intensive Course on dates to be announced after January 1st.

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**Delaware-Blackford County Medical Society** members held a general business meeting on October sixteenth, at Hotel Roberts, Muncie. Thirty members attended the meeting.

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**Floyd County Medical Society** members met at the Frances Cafeteria, in New Albany, on September fourteenth. Dr. M. B. Strange, chairman of the medical fees committee, made a report of the committee to the eighteen members present.

Also a regular business meeting was held on October twelfth, at which thirteen members were present.

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**Fort Wayne (Allen County) Medical Society** members held a meeting on September fourth at the Chamber of Commerce. The speakers for this meeting, both of Fort Wayne, were Dr. H. C. Dunstone, who spoke on "Depressions," and Dr. Anderson Nettleship, whose subject was "The Pathology of Protein Starvation."

At another meeting on September eighteenth, at the Chamber of Commerce, "Home Medical Care of the Community Chest Agencies," was discussed by Mr. James V. Lavin, president of the Fort Wayne Community Chest.

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**Greene County Medical Society** members held a business meeting on October eleventh, at the Freeman Greene County Hospital, in Linton, at which eight members were present.

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**Grant County Medical Society** members met at Marion, on September thirteenth. This meeting was held for the discussion of current business. Eight members were present.

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**Howard County Medical Society** members met in Kokomo, at the St. Joseph Memorial Hospital, on September seventh. "Medical Legislation, with Special Reference to the Wagner-Murray-Dingell Bill" was discussed by Mr. Albert Stump, of Indianapolis. This was a joint meeting with the Auxiliary, and twenty-nine members and guests were present.

The members met again on October fifth, at the St. Joseph Memorial Hospital, in Kokomo. The guest speaker at the meeting was Captain James A. McClintock, of Billings General Hospital, Fort Benjamin Harrison, who presented a paper on "Treatment of Osteomyelitis by Skin Grafting." Eighteen members were present.

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**Parke-Vermillion County Medical Society** members met on September nineteenth, at the Vermillion County Hospital. The speaker of the evening was Dr. Alexander W. Cavins, of Terre Haute, who discussed "Recent Advances in Gynecology." Seven members attended the meeting.

**LaPorte County Medical Society** members held a meeting on September twentieth, at Wildwood Inn, Michigan City. The guest speaker, Dr. Robert O. Ritter, of Chicago, discussed "Anterior Poliomyelitis." Twenty-five members were present.

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At another meeting on October eighteenth, the members met at the Wildwood Inn, Michigan City. The guest speaker was Dr. Grant E. Metcalfe, of South Bend, who discussed "New Methods in the Treatment of Psychiatry." Sixteen members were present.

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**Posey County Medical Society** members held a business meeting on October second, at the Shoultz Funeral Home, New Harmony. Nine members were present at this meeting.

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**Tippecanoe County Medical Society** members held a meeting at the Lafayette Home Hospital, in Lafayette, on September eleventh. Dr. John R. Thrasher, of Indianapolis, was the guest speaker, and discussed "Management of Syphilis." Forty members were present.

The members held another meeting at Lincoln Lodge, in Lafayette, on October ninth. A panel on "Industrial Medicine" was held, thirty minutes being allowed each discussant who spoke in his particular field. Dr. E. H. Carleton, of East Chicago, spoke on "Physical Examinations in Industry"; Dr. E. B. Lamb, of Indianapolis, spoke on "The Physician's Role in the Placement of Workers in Industry"; and Dr. L. W. Spolyar, of the Indiana State Board of Health, spoke on "The Newer Industrial Skin Diseases." Forty-five members and guests attended this meeting.

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**Vigo County Medical Society** members were among the first group of persons to be taken on a tour of the manufacturing area of the Wabash River Ordnance Works, at Newport, on July twenty-sixth. Colonel W. J. McConnell, Chief of the Industrial Hygiene Branch, Safety and Security Division, Office of the Chief of Ordnance Department, was the main speaker at the luncheon. The group met at the plant hospital for an inspection tour before the luncheon, and following Colonel McConnell's talk were taken through the manufacturing area.

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**Wabash County Medical Society** members were guests of Dr. L. Z. Bunker and Dr. O. G. Brubaker, both of North Manchester, at a dinner meeting on September twelfth, at the Sheller Hotel, in North Manchester. Music was provided during dinner by a string trio, after which Dr. Robert M. LaSalle, of Wabash, formerly of the Army Medical Corps, told of his work in Europe.

"Amebiasis is being reported with increasing frequency in U.S. Army troops overseas. Although the disease is endemic in every area where troops are stationed, poor environmental sanitation in some places makes it relatively more difficult to prevent transmission of *Endamoeba hystolytica*."

*Bull. U. S. Army Med. Dept.* (*Mar.*) 1945, *p.* 10

Amebiasis can no longer be considered a "tropical disease"—it has recently been described as endemic in New York as well as in other sections of the country.

**DIODOQUIN**

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is safe for use whenever amebiasis is suspected, or in preventing transmission through "carriers." Diodoquin can be used in large dosage, by oral administration, over protracted periods without ill effect. Diodoquin contains 63.9% iodine, is destructive to E. histolytica and Trichomonas hominis.

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RESEARCH IN THE SERVICE OF MEDICINE

## COUNCILOR DISTRICT MEETING

**The Third District Medical Society** members met at Scottsburg, on September twenty-sixth. The Councilor, Dr. Augustus P. Hauss, of New Albany, gave an excellent report. The guest speakers were Mr. Ray E. Smith, of the Indiana State Medical Association, who discussed the state meeting, and the Publicity Column; Dr. C. H. McCaskey, of Indianapolis, who discussed the "State Rehabilitation Plan"; Dr. Philip E. Blackerby, Secretary of the Kentucky State Board of Health, Louisville, who discussed "Federalization of Medicine"; and Dr. Lytle Atherton, of Louisville, who discussed "Hematuria." The invitation of the Lawrence County Medical Society to hold the 1946 meeting in Lawrence County was accepted. Thirty-five members and guests attended the meeting.

## *WOMAN'S AUXILIARY to the Indiana State Medical Association*

**President—Mrs. F. M. Gastineau, Indianapolis**
**President-elect—Mrs. S. J. Petronella, East Chicago**
**Corresponding Secretary—Mrs. C. L. Bock, Indianapolis**
**Treasurer—Mrs. A. W. Ratcliffe, Evansville**
**Press and Publicity—Mrs. A. B. Richter, Indianapolis**

### ALLEN COUNTY

Dr. Morris Fishbein, editor of *The Journal of the American Medical Association*, was the guest speaker at the annual public relations meeting of the Allen County Auxiliary, on October ninth. His subject was "Current Medical Legislation Affecting Medicine." A luncheon for auxiliary members preceded the address, to which many civic groups had been invited.

### CARROLL COUNTY

Mrs. C. C. Crampton and Mrs. C. L. Wise were in charge of the entertainment for the wives of the doctors who attended the District Councilor meeting at Delphi, on October seventh.

### FLOYD COUNTY

On October eleventh Mrs. F. T. Tyler entertained twenty-two members of the Floyd County Auxiliary at her home. Mrs. A. N. Baker, president, appointed the committee chairman for the year. A special committee was named to arrange the entertainment of members attending the state meeting at French Lick.

### LAKE COUNTY

"Women of Detention" was the subject of a talk given by Mrs. Mary Powers, of Chicago, at the October meeting of the Lake County Auxiliary. Mrs. Powers has been a member of the Chicago Police Department for many years. This meeting was open to the public.

### VANDERBURG COUNTY

Mrs. Frank Gastineau, president of the Woman's Auxiliary to the Indiana State Medical Association, was guest speaker at a luncheon held at the McCurdy Hotel, in Evansville, October ninth. Wives of doctors in nearby southern Indiana counties were special guests.

### VIGO COUNTY

The members of the Vigo County Auxiliary met at the home of Mrs. H. R. Vandivier, on October eighth. The group sewed for the Wakeman General Hospital, at Camp Atterbury. Following a cooperative luncheon a business meeting was held.

## *Books*

### BOOKS RECEIVED

**ONE HUNDRED YEARS OF GYNAECOLOGY,** 1800-1900. By James V. Ricci, M.D., Clinical Professor of Gynaecology and Obstetrics, New York Medical College, Director of Gynaecology of the City Hospital, New York; Director of Gynaecology and Obstetrics, Columbus Hospital. 651 pages. Price $8.50. Fabrikoid. The Blakiston Company, Philadelphia, 1945.

**THE OSSEOUS SYSTEM, A HANDBOOK OF ROENTGEN DIAGNOSIS.** By Vincent W. Archer, M.D., Professor of Roentgenology, University of Virginia Department of Medicine. 320 pages with 148 illustrations. Price $5.50. Cloth. The Year Book Publishers, Incorporated. Chicago, 1945.

**THE YEARBOOK OF PSYCHOANALYSIS.** Editors: Drs. A. A. Brill, Henry Alden Bunker, Bertram D. Lewin, and C. P. Oberndorf, and Sandor Lorand, M.D., Managing Editor. 370 pages. Price $10.00. Cloth. International Universities Press, New York, 1945.

**THE PSYCHOANALYTIC STUDY OF THE CHILD.** By Editorial Board of the International Universities Press. 423 pages. Price $6.00. Cloth. International Universities Press, New York, 1945.

**ESSENTIALS OF CLINICAL ALLERGY.** By Samuel J. Taub, M.D., Professor of Medicine, Cook County Graduate School of Medicine. 198 pages with 16 illustrations. Price $3.00. Cloth. The Williams & Wilkins Company, Baltimore, 1945.

### REVIEWED

**TECHNICAL METHODS FOR THE TECHNICIAN.** By Anson Lee Brown, M.D., Director of Dr. Brown's Clinical Laboratory and School for Technicians, Columbus, Ohio. 706 pages with 229 illustrations. Fabrikoid. Price $10.00. B-B Printing Company, Columbus, 1944.

This book is written entirely for the technician. The physician will find very little of interest to him, nor information that is not already published in standard books of clinical pathology. However, it is an excellent book for the technician. It is made up in an outline form.

The author gives a description of his own "Test for Syphilis," which is a micro-precipitin test, using powdered beef testicle as antigen. Illustrations include some excellent color plates of blood cells.

HENRI LECLAIRE, M.D.

# THE JOURNAL

OF THE

# INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

*ISSUED MONTHLY under Direction of the Council*

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 38 DECEMBER, 1945 NUMBER 12


## THE MEDICAL PROFESSION TODAY AND TOMORROW*


WATSON B. MILLER

Federal Security Administrator

WASHINGTON, D. C.


When my good friend, your chairman, asked me to attend this important luncheon and talk to you, I experienced a definite thrill. I was to come back to my home state and meet with its leaders in the medical profession, at a time when the drama of medical discovery and progress had reached unparalleled heights. I was to meet with you at a time when you are exploring ways of bringing the full advantage of today's scientific developments to the people of this great state—ways now made possible because the war is over and the victory is ours. I was to share your pride in the magnificent war record made by members of this association, by those whose quick response to the call for doctors in the armed forces placed our state among the very first to meet its quota, and by those who so valiantly carried the load at home, often at great risk to their own health and life.

This is a strategic moment in the history of medicine in this country and in the world. While we were forced to fight and conquer the enemy armies, our critical need brought about startling new weapons against the enemies to health. We are now ready to spread their benefactions throughout the land.

Medicine at war has met the most crucial test of our times. Lifted in spirit by the demands of the war, and by the singular privilege of doing the healing job while at the same time being part of the machine that destroys the enemy, American physicians will be on the crest of a wave of desire to serve at home as efficiently as at the front.

Not the least of the gains of our wartime experience is the increase in understanding between medicine and government as we have worked together for the common cause. The urgency of the hour made such understanding imperative.

During the period of demobilization we must strive to continue this relationship so that medicine in and out of government will work in partnership and not in conflict. In this postwar era, many more doctors will be in government service than ever before, and the role of medicine will be greatly affected by this fact.

What will be the main concern of our doctors in the years immediately ahead? What will be their interests and characteristics? How will the some fifty thousand doctors who served in the war be affected by their service? What have they learned to pass on to us? What do we expect of them, and of the young students who will be guiding this society twenty years hence? Can we look forward with assurance to the time when the diseases which are now the major causes of death will be as much under the control of our knowledge as typhoid fever, cholera, and plague are today?

As we find the answers to the most baffling of our problems, do we have the will and the skill to apply that knowledge?

We must not mind controversy and discussion—the great lesson of history, after all, is that progress comes only as a result of recurrent conflicts and their resolution.

The history of medicine and the advance of science to serve medicine have many recurring episodes

* Presented before the War Participation luncheon of the Indiana State Medical Association, at French Lick, November 7, 1945.

dramatizing the problems and conflicts that trouble us today.

One of the greatest needs of today is for the physician to be aware of every new scientific development in his profession, and also to preserve a balance which enables him to view his patients as a whole.

The age-old conflict between the advocates of the precise scientific formula for a certain malady, and those who put equal store in the intangible and obscure human characteristics which contribute to the malady, has never been so alive since the era of the miracles of Christ. We are pressed to discover methods to translate our most specialized medical knowledge into terms and tools that serve the masses at the crossroads of the world. We are pressed, too, to bridge the eternal gap between those to whom the best is available in the way of medical service because of wealth or the accident of geography, or both; and those who have access to little or no service because of the lack of wealth or the accident of geography, or both.

To solve this dilemma will be the great challenge of our organizational genius of this portwar world. To do this without losing too much of the individualistic characteristics of the practice of medicine will be an added challenge.

It seems, then, as we look ahead, that the task of the future in spreading the service of physicians, while at the same time keeping the standards high, lies in the field of organization.

Always an individualized art, the practice of medicine may lose much if the organization to distribute the fruits of its labors is not wisely and deftly brought about. It is not a vain fear that makes us unwilling, or at least resistant, to give responsibility for the most personalized of all services to the most impersonal part of our society, namely, government.

The larger the unit of government, or for that matter any organization, the farther away from the point of service responsibility lies, and the more likely we are to lose the very quality which has made the doctor the almost mystical figure he has remained from the dawn of history.

It will be the obligation of all of us working together to be responsible for extending "social security" in our communities, to have sufficient imagination to accomplish the next four or five important steps in the extension of medical and health services in this country in such a manner that decades from now we will look upon the individuals who practiced medicine within the framework of this revised and enlarged organization as we remember the great physicians of the past—the "Pop" Welchs and the Mayos. In order to do this, we must have physicians distributed over the country in such a way that tendencies to have a surplus of medical services in some centers and none in others will be lessened.

To find the exact size of the unit most efficient for any given community will need continued study and constant experimentation. It will also need acceptance of the principle that all parts of the community have responsibilities. Individual physicians will not be able to see for themselves, always, the most effective way to get the needed tools for the practice of medicine.

The plan in national terms for the extension of these tools and facilities is not, perhaps, immediately helpful to anyone, but a national plan which would be composed, like the pieces of a jigsaw puzzle, of a series of state and community plans which, fitted together, would have real significance. To accomplish such a thing, we need acceptance, first of the principle of planning; and second, of the principle that medicine must cooperate with all elements in the community and, if possible, take the lead among them and be the springboard to which the community looks for guidance and help.

I think we can all agree that social security is one of the pressing problems awaiting solution, and that the way we solve it will influence the pattern of service and the field of government for generations to come. Included in our concept of social security nowadays is, of course, health and medical services.

There are a number of practical problems to be solved if we are to extend social security in the medical and health fields. I shall mention a few:

1. Better distribution of medical personnel.
2. More adequate facilities of all kinds.
3. The economic and financial phases of health security.
4. Research.
5. Medical education.

I think the most urgent need for the immediate future is to insure a better distribution of doctors and other medical and health personnel throughout our nation, a situation of which we were vaguely aware before Pearl Harbor reached crisis proportions as a result of supplying doctors to the armed services.

After the war we certainly want to go back to at least as high a standard as before, and in many areas of the country we must do far better than before. Consider the problem then for a moment from the point of view of this state, and then from the point of view of the nation as a whole. Indiana has sent more than twelve hundred doctors to war—all kinds, from your most skilled leaders to your least experienced interns. Some unquestionably will go back immediately to the post they left. Some will have made the supreme sacrifice on the field of battle. Some, in fact, of those serving at home will have made the supreme sacrifice, too. Many men who come from one type of community will want to move to another type—the answers to the American Medical Association questionnaires are showing a variety of changing attitudes on the part of the younger men.

Many of the very young physicians will not have had any roots—thirty or forty thousand doctors will be in a state of flux—and a large percentage

of them could perhaps be persuaded to assist in the solution of this very acute problem. The question is, how?

One striking fact stands out in these questionnaires mentioned: very few men have a burning desire for the missionary life of a rural practitioner. And why? Because we have made it practically impossible to practice good medicine in our small isolated communities in America, and not only to practice good medicine, but to live a rich and satisfying life in other ways. This is the real challenge to our organizational genius. This is the real pioneer job of the next few years. Such an accomplishment makes imperative a partnership of government, of all kinds, and medicine.

We must do as integrated a job as we finally did in the war responsibility. We must support some kind of a subsidy plan to insure the doctor's economic security, and some other plans to insure that he has facilities to meet his professional needs and the medical and health needs of the people he serves.

Great Britain, in facing this problem, has given consideration to an interesting recommendation which would require a young doctor, before he would be free to practice anywhere, to serve a year under an older man. This puts the burden for spreading service on the young physician, and may be one possibility. There are others, which will be accomplished if each state knows its own problems and takes definite steps to meet them.

Almost all the other problems spring from the one of distribution.

The second one I want to mention is the extension of facilities in some planned way. Those needed fall into several well-defined categories: new general hospitals especially in rural areas; new tuberculosis and mental hospitals; hospitals to care for the chronically ill; and health and diagnostic centers.

Every community in the country should have access to all types of facilities, and must have them in the future if they are to enjoy good medicine and avoid the social heartbreak of a group of citizens in need and no place to take care of them. We are late already in providing even the simplest health centers and diagnostic services in most sections of the country, but we are becoming increasingly more aware of the urgency of the need. We will find that our ability to locate doctors where needed depends in large measure on our ability to promise them adequate facilities. Here, too, we must have a partnership with government, both on financing and planning for service. Every state should have a health committee made up of citizens representing hospitals, medical profession, public health activities, community welfare services, and even the architectural profession, as well as the general public. Undoubtedly, we will have a postwar building program of some sort. So much had to be neglected during the war.

Indiana, following its record for progressiveness, has already started in an orderly fashion to effect a state-wide hospital program. Two measures enacted at the last state legislative session promise much toward raising the standards and increasing the area of your hospital service—the law providing for the licensing of hospitals, and the provision for a state-wide survey to determine the hospital needs of the state. I understand your State Board of Health is now getting out the hospital schedules of information to all institutions, and expects to finish its survey by the end of the year.

Here I should like to call to your attention the main points in the proposals of the public health service for the hospital of the future. It would not be a single, independent institution, but part of a system of health services, coordinated functionally and administratively to provide complete health care to every community. At the center of a state or regional system would be the base hospital, a large institution connected with professional schools. Here would be concentrated specialist services and facilities where research, training, expert diagnosis, and treatment for difficult cases would be provided. Serving more directly the people of the area would be a series of district hospitals. These would be somewhat smaller institutions, rendering complete medical service and providing training for interns and nurses. In outlying areas there would be still smaller rural hospitals. These would provide well-equipped workshops for private practitioners and health agencies, and would be the source of more limited types of service. And in remote, sparsely populated areas we can visualize the health center, a modern building to house the public health department and the offices of physicians and dentists.

The lessons of the war may come to change our thinking on what is best suited to the care of the mentally ill. The advancement of public health and preventive medicine will bring the health center into a place of prominence in our country which it has not occupied up to now.

Diagnostic facilities of all sorts must be made easily available to the rural practitioner, and this will tend to make the community more aware of the advances in medicine and more determined to take advantage of them.

Thirdly, no discussion of social security would be complete without a mention of how the individual is to meet the costs. We could all agree, I suppose, that insurance to cover loss of wages resulting from permanent disability would be a much-needed next step. This could be accomplished through adaptation of the present old-age and survivors insurance program. Insurance to cover the cost of illness, too, must come. Many experiments are under way which will demonstrate the extent to which medical society plans can meet this problem.

The very considerable advance of industrial medicine during the war, and the awareness of organized labor of the need for making "health security" a paramount issue in all its thinking will have a profound effect on how some of these problems will

be solved in the years immediately ahead, for we have never had such a widespread interest in health problems as exists today. This interest will not lessen as the men get back from the front, for doctors and patients alike have seen a quality of medical practice never before equalled.

As it is revealed, the story of war medicine in World War II will prove to be more thrilling than that of any other era in medical science. We are beginning to learn that many questions troubling us for decades have been answered by groups of dedicated souls working together in cooperation. The results accomplished by intensive research, initiated to secure answers to questions raised by the surgeons general, are monuments to the spirit of cooperation between government, medicine, and education. We know something of the more outstanding developments—the treatment of malaria; the use of blood plasma; the valiant developments in orthopedic and neurosurgery; and the vast new fields which have been opened by the discovery and use of penicillin.

Here again is a field for partnership with government for the common good. The war research program in all fields has demonstrated how effectively the government can work with our great research scientists and institutions. We must plan for its continuance, especially in the fields still a mystery—cancer; the diseases of the heart; chronic diseases of all types; and particularly in clinical psychiatry. The war has brought immeasurable progress in the application of psychiatry, far exceeding the first great stride forward after the last war.

The work that is being done in all the services—especially in the air corps—and in the war shipping administration's rest homes for seamen has demonstrated what we can expect in the future through application of these psychiatric techniques to the problem of peace. There are great lessons to be learned here, and these lessons must be translated immediately into the practice of medicine of the future. To do this will be one of the great challenges, and one of the most difficult to meet. The place where it must be met first is in our medical schools.

In common with all branches of education, the study of medicine will undergo profound changes to meet the demands of the immediate future. Some of the traditional lines of study will have to be radically changed to meet the needs of the young physician of five years from now.

First, there is the problem of meeting the immediate needs of the doctors returning from the war for residencies to prepare for general practice again, and for more-advanced residencies to prepare for the specialties. Then there is the need for organizing short courses of the refresher type. There is need also for some direction for the men coming back, so that the type of training will be an aid to our number one problem—distribution.

For the long-time program of improving the standard of medical practice, a much more intensive program of refresher training for physicians in practice must be devised. And, finally, the general curriculum of the medical schools must keep up with the times.

One of the most important fields in which medical education needs direct attention is psychiatry. I do not mean that every doctor must be a psychiatrist, or even that a much-needed increase in the number of psychiatrists will wholly answer the problem. I mean, rather, that greater attention must be given to developing an attitude of mind enabling the doctor to take into consideration the emotional and environmental factors which contribute to physical illness. In the process of educating the young physician of the future, this type of training is essential if he is to understand these factors and, through this understanding, to deal more capably with patients of all types.

Indeed, we must count on medicine to develop the kind of personality which is needed to soothe the harrowed spirit of the postwar world. It will not be enough to practice perfect medicine in the perfectly-equipped diagnostic center or in the hospital in a mechanized routine way. It will rather be necessary to meet some of the intangible factors which will be disturbing the inner serenity of the patients of the next decade. There will be very few people who will not have been upset in some way by the war or postwar adjustments.

It is to be hoped that, in the process of demobilization, the teachers will return early to our medical schools and hospitals, and that these schools will also seek out the men, and women, too, who have learned how to apply knowledge which seemed radical and even queer a decade ago.

Some of these young physicians have done a tremendous—a remarkable—job. They have learned great lessons to pass on for the future. It has been their responsibility to keep very valuable men sane, sound, and happy. They have been encouraged to apply new knowledge which it would have taken traditional medicine decades to accept. We will be wise if we seek out these leaders and put them in touch with the young doctors of the future, who will be a little bit jealous because they have not had the war experience. They will be anxious to learn all that they can from those who actually have been participating. It will be tragic if ten or fifteen years from now we have cause to regret that we did not take advantage of the knowledge and experience of the men who have carried the burden in the heat of our day, and who can teach us lessons which we can learn only because thousands have died to give us the freedom to be taught.

The medical profession of tomorrow will depend to a great degree on the vision, courage, and perseverance of the medical profession of today. And you have proved that you are not lacking in any of those qualities. For all the other factors in the broad-scale health program toward which we shall work, we must look to you for leadership. But insofar as government, as represented in the Federal Security Agency, can support and imple-

ment that program, you can count on enthusiastic cooperation. You have had that kind of cooperation from Governor McNutt, in whose shoes I now stand. It will be my constant purpose to uphold the principles he established.

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# THE GENERAL TREATMENT OF ARTHRITIS*

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Arthritis is at the present time the most prevalent chronic disease in the United States. The National Survey of the Public Health Department estimates that there are 6,850,000 rheumatic cases in this country. This does not include the vast number of young people in the armed forces who have developed arthritis during the war years.

Mental and nervous diseases head the list of work days lost, but arthritis comes second with 97,200,000 days lost from work each year. This is a staggering figure, and affords a great opportunity for the general practitioner as well as the specialist, for if every doctor plays his part in the early adequate care of these patients, he is making a real contribution to the health of the nation.

There are two main types of disabling arthritis: the rheumatoid, or atrophic; and the osteo, or hypertrophic. It is essential to distinguish between these two groups because the treatment and prognosis are quite different. In the mixed cases it is important to determine which type is predominant.

### DIFFERENTIAL DIAGNOSIS

Rheumatoid arthritis, as we shall call it from now on, is a constitutional disease of early life, occurring most often between the ages of twenty and thirty, and is five times as prevalent in women as it is in men. An exception to this is Strumpell-Marie arthritis, which seems to attack young men more frequently than women.

Degenerative joint disease—hypertrophic osteo-arthritis—is a disease of middle and old age, seldom appearing in people under forty-five. Ninety-seven per cent of all older people have it in some of their joints, chiefly the larger ones, such as the neck, back, hips, knees, and terminal joints of the fingers (Heberden's nodes). These joints have borne the strains and injuries of life. This type of arthritis, often called "rheumatism," is a bone disease with little soft tissue change. The bone edges grow hard bony ridges and spurs, and the cartilages become eroded and friable. There is no ankylosis. Seldom is there swelling or heat, but often tenderness over the growing spurs, and pain with use and weather changes. Osteo-arthritis is rarely crippling, except when it occurs extensively in the hips and knees.

Rheumatoid arthritis, on the other hand, is an inflammatory process in the synovial membrane and periarticular tissues surrounding the joints. It usually occurs in the small joints, such as the second joints of the fingers, the wrists, elbows, knees, ankles, and metatarsals. It occurs symmetrically and bilaterally. The symptoms are stiffness, heat, swelling, and soreness and pain about the joints, with fluid in the early stages. Later this fluid is absorbed, and the synovial membrane becomes dense fibrous tissue. Excessive proliferation of the synovial cells causes thickening of the synovial tissue. The cartilage is destroyed and often breaks into loose pieces. After the acute inflammation subsides, adhesions cause ankylosis, and bony fusion may occur, or the joint surfaces become rough, and the capsules loose, resulting in an unstable joint. The ultimate deformities resulting from this type of arthritis can be extensive and crippling unless the disease can be arrested and deformities prevented. Most of the bedridden wheelchair invalids start from this rheumatoid type. So let us carefully consider the early adequate treatment of such potential cripples, realizing that only thus can deformities be prevented. Recent statistics show that in this country and in Sweden 75 per cent of these patients can go back to some kind of work; 20 per cent are incapacitated; and 5 per cent have not the stamina to recover.

In diagnosing all types of arthritis, x-ray is, of course, essential. The affected joints should always be x-rayed in order to determine the extent of local changes, for prognosis depends on this knowledge. An x-ray of the hands is useful in distinguishing the type of arthritis present. Early rheumatoid will show soft tissue swelling and atrophy of the bone near the joints. Later the cartilage will be thin and the joint-space narrowed, with irregular surfaces. Ankylosis frequently occurs in advanced cases. In the hypertrophic type, which never ankyloses, x-rays will reveal bony lipping and spurs on the edges of the joints.

Laboratory tests also show characteristic differences. The rheumatoids are usually anemic, with rapid sedimentation rate, low sugar tolerance, and the agglutination reaction with hemolytic streptococci is positive in 50 per cent of typical cases. The osteo-arthritic cases show none of these laboratory findings. From the clinical picture, physical examination, laboratory tests, and x-rays, there is little difficulty in diagnosis. In treating arthritis,

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* Presented before the General Meeting of the Indiana State Medical Association, at French Lick, on November 7, 1945.

we must remember that every individual is a case and that every case is an individual.

The treatment of hypertrophic or osteo-arthritis is much more simple than in rheumatoid arthritis, its objective being to check the growth of ridges and spurs and to stop pain. Since such growth is due to reaction of the bones to slight traumas over a period of years, the idea is to eliminate such injuries as far as possible. Many such strains are due to faulty posture, which affects the neck, hips, and knees. Overweight also causes strain. The typical hypertrophic back is often the result of strain from a "sway back" posture. A tilted pelvis and flat feet mean sprung knees. Often occupational strain results in bruised fingers. Hallux valgus is an example of degenerative joint disease produced from injury, resulting from wearing too tight shoes.

The first step in treating a hypertrophic joint is to rest it. In extreme cases it is beneficial to immobilize such a joint in a plaster cast for a week or more. After such a complete rest invariably the joint is painless and more movable; and as it is protected from further strain, the bony growth ceases.

Heat is always advisable in these cases, especially for older people whose circulation is poor because of arterial changes. Moist heat, if used regularly, stimulates sluggish circulation and relieves soreness and pain.

Diet does not seem to play an important part in curing degenerative joint disease, although in the case of overweight patients a diet low in carbohydrates and sweets is advisable.

If constipation is present, it must be controlled. Two glasses of hot water with the juice of a lemon taken before breakfast can be supplemented by cooked fruit for dessert, and apple sauce the last thing at night. Sodium phosphate has been found to help these cases, not only in elimination but in actually making them more comfortable.

Osteo-arthritis in women has been called "menopausal arthritis" because it so often appears at that time of life. Some early cases are benefited by giving them estrogens. It seems to relieve fatigue and pain, as it does arthralgia following castration.

Permanent relief from pain in the back, neck, hips, and knees, however, comes principally from correction of faulty posture which causes the strain. This is done by special rest positions and exercises. The position which best relaxes the back is one of lying down flat on a firm surface, preferably the floor or a hard bed. We call it hyperextension. The knees are bent, with a pillow placed under them. In this position the chest is high; the neck and dorsal spine are straight; and the lumbar spine is flat. After a half hour in this position, the curves of the back straighten out. Then the patient turns over and rests for a second half hour, face down over a pillow. These positions bring the greatest relief and quickest permanent results if taken three times a day.

I use a series of simple exercises which have proved extremely beneficial in all cases, and which, if done regularly, keep patients in good general health and posture:

1. Lie flat on a hard bed or floor, pillow under knees, hands under head. Breathe deeply in abdomen, keeping chest high; then drive the air out by contraction of abdominal muscles. Repeat ten times.

2. Stretch ribs and shoulders upward, breathing deeply, first right side, then left. Repeat ten times, each side.

3. Pull in abdominal muscles slowly and firmly. Repeat ten times.

4. Tighten buttocks muscles, roll pelvis upward and contract abdominal muscles, slightly lifting tip of spine to flatten back—hold and relax. Repeat ten times.

These exercises should be done twice a day for a month; then increasing the number to twenty times each. After two months the exercises may be done standing against a wall. With increased proficiency, the number can be increased indefinitely.

Supplementing these exercises, back braces and corsets are helpful in relieving strain and correcting posture. Occasionally elastic knee supports are of value, and flat pronated feet have to be corrected by plates. Operative removal of bony ridges and spurs is rarely permanently successful, since they tend to recur. Osteo-arthritis is not benefited by gold salts or any other drugs, with the possible exception of aspirin to relieve pain.

Hospitalization is advisable in cases of acute strain, where complete rest from weight-bearing is indicated and joints need to be immobilized in plaster of Paris casts. Let me repeat that osteo-arthritis is the result of continued injuries, chiefly from poor posture.

Let us now consider rheumatoid (atrophic or proliferative) arthritis, which is a very grave problem and demands early, adequate, watchful care.

My first step in diagnosing and treating a rheumatoid arthritic is to take a complete history. From long experience I have found that the best results come from a three-way history. First comes a careful medical checkup, with a complete physical examination, including laboratory tests and x-rays. Dates of past illnesses, injuries, and operations are important, especially those occurring during the year preceding the onset of joint symptoms. The reason for this becomes apparent as the second part of this history-taking develops, which I call a "Relationship History." It correlates the setbacks in the disease with the emotional reactions to various adverse episodes in the patient's business or family life, such as quarrels, financial reverses, moves to new surroundings, deaths—all the things that make us or break us, according to how we take them. Interesting, too, are the habits of eating and sleeping, thinking, and acting that are conditioned by family living. Is the patient's home and business life congenial or strained, happy or tense?

The third history is a "spiritual" one, and the most far-reaching and revealing of the three. I try to find out what beliefs the patient lives by. Do his beliefs really affect his thinking and actions, especially towards the people closest to him, or are they purely intellectual? Is his security in material things and self-effort, or has he a sustaining faith which carries him through the emergencies of his life? My experience has been that people are often blind to the motives behind their actions, and are quick to respond to questions which lead them to see the connection between their inner approach to life and their physical health. All this kind of information should be known in order to carry out "complete treatment."

A suprisingly large number of the people whose histories I have taken show a definite connection between their arthritic symptoms and their response to the exigencies of life. If their inner lives are secure and happy, there is very little joint reaction; if they feel insecure or are unhappy, they will have frequent flareups of their joints. Often the first symptoms follow some family trouble, and the future course of the disease is determined by the kind of character they have developed over the years.

The two physical objectives in treating the rheumatoid case are first to stop the course of the disease; and second, to prevent deformities so that the patient may live a normal life. Because these patients are always tired and underweight, we begin with rest. Some need hospitalization for prolonged bed rest. These people usually do better away from home. Being in the hospital gets them away from their accustomed surroundings, and they rest better. Also, it gives the doctor his best opportunity to study them, and to get to know them, which is important.

As a tired person always droops into poor posture, the same positions and exercises are prescribed for these rheumatoid cases as were used in the treatment of the osteo-arthritics, but for a different reason. Their poor posture must not be allowed to interfere with normal functioning of the abdominal viscera through crowding. Taken morning and evening, these exercises aid digestion and stimulate circulation through the abdomen. The flat hyperextended position gives the heart, lungs, and diaphragm their best chance to function. A little explanation will make this routine clear to the patient, and he will cooperate fully.

Physical therapy should always be given at once, for it, too, increases circulation. Moist heat and massage relieve spasm and dilate the blood vessels to the muscles and joints. Hot fomentations over the affected joints twice a day for a half hour are beneficial. This is done with steaming wet towels wrung out as hot as the patient can stand them. Baking, diathermy and heat lamps also help, although the wet heat is the best. Steam baths are of distinct benefit, because they produce elimination through the patient's skin. Often the sweat of the rheumatoid case is acid, pH 5.0. With repeated sweats it becomes neutral, or pH 7.0. When this point is reached the patient feels better. If, however, he goes over to the alkaline side, he feels worse. If a steam bath is not available, a hot, deep tub bath for ten or fifteen minutes is almost as effective in relieving pain and stiffness.

There is no specific diet that can be prescribed for rheumatoid arthritis, although we know certain facts which help in planning a balanced diet. Dr. Ralph Pemberton has shown that many cases have low sugar tolerance; therefore, the diet should contain the minimum amount of sweets and carbohydrates. Whole grains and brown sugar are better than processed flour and white sugar. These patients invariably lack vitamin C, and they require three times as much as a normal person to maintain their proper blood level. They are frequently deficient in vitamin A; and the red, shiny tongues we used to call the arthritic tongue have proved to be due to vitamin B deficiency. Such tongues show a marked change when vitamin B is supplied. In regard to vitamin D, I quote the Primer of Arthritis of the Committee of the American Rheumatism Association: "Concerning Vitamin D, the Council on Pharmacy and Chemistry of the A.M.A. has never accepted such preparations for the treatment of arthritis."

The diet, therefore, should be well-balanced with protein, carbohydrates, and fats and should be rich in vitamins and minerals. In my experience extra vitamins are indicated, as most of these cases have been deficient for a long time, and their tissues change slowly even with large doses of vitamins. The repair in arthritis often takes years. Almost all rheumatoids are anemic and need iron or iron and liver. A tablespoonful of "Black Strap" molasses once a day will improve anemia. Apparently, the sugar in it does no harm.

In many cases gastric analysis shows a lack of hydrochloric acid, which may be the cause of the failure to absorb iron and vitamins. This acid should be supplied when indicated.

Medicines, such as sulphur, bee venom, and snake venom are of little value, although many people have pinned their hopes to these. Cathartics are actually harmful because they hurry along the food and prevent absorption.

Since Jacques Forrestier first used gold salts in the treatment of rheumatoid arthritis, it has been used increasingly. It is still a dangerous drug because it may injure the liver and kidneys, and damage the white cells and platelets. Skin rashes are often frequent and serious, and death may result. Because gold is eliminated slowly, the danger comes from raising the accumulated level to the saturation point by too large or too frequent injections. It is well to begin with small doses of 10 mg. injected intramuscularly, and if no allergy reactions occur, another 10 mg. can be repeated in four days; then 25 mg.; and then 50 mg. every week. I rarely use 100 mg. since 50 mg. seem to give as good results and lessen any danger, although prolonging the treatment. In order to avoid

any complications, it is well to examine the urine each month for albumin, white cells, and casts. The hemoglobin, white count, and platelet count should be done every week. If the number of platelets should get below 200,000 it is well to postpone the next injection for a week; for if these platelets are destroyed, death results. I use one cubic centimeter of crude liver extract with each gold injection for its blood-forming qualities and its vitamin B.

If a skin rash should develop at any time during treatment, stop the injections. Or if the kidneys should show irritation, stop the gold. I always have a functional concentration test of the kidneys before starting to give gold; and unless such blood and urine tests can be given regularly, gold should not be given.

In the early days of gold treatment, each series amounted to 1 or 1½ grams of gold. After three months this was repeated. Recently, better and more permanent results have been obtained by tapering off, giving 50 mg. every two weeks; then once a month; and then 25 mg. once a month for as long as seems necessary to control the sedimentation rate and the symptoms.

There is no known antidote for gold salts. Once given the body has to eliminate them. So don't use gold if you don't know all about it, and use only in acute active cases. As far as cures are concerned, the results are not miraculous, but enough active patients are relieved to make gold treatment worth while, in spite of the risk.

I have used x-ray treatment for arthritis for twenty-five years, ever since Dr. Kahlmeter, of Stockholm, first wrote about it. Treatment is given in series, each exposure being over a different area in order to prevent skin burns. The routine is as follows:

> 135 K.V. 5 Ma., 13 inch distance, with approximately 4 mm. of aluminum filter, giving approximately 150 R. units at each sitting—treating one area at each sitting, and giving two treatments a week, a total of six treatments, with a total of 900 R. units in each series. The series is repeated in four weeks, and possibly a third series, after an eight weeks' interval, depending upon the acuteness of the symptoms.

I have had excellent results with rheumatoid cases. Swelling decreases, soreness and pain subside, and there is less thickening of the villus tissue and pannus formation. Sometimes three or four series are necessary, and the results are not fully evident for a year. I have found x-ray treatment beneficial when gold was contraindicated, and have also used it with gold. It is routine treatment in all cases of Strumpell-Marie arthritis. It has a remarkable effect on these stiff spines, and in the early stages it restores flexibility and apparently cures the disease. In fused spines it relieves pain and spasm.

### CHRONIC INFECTION

Since infection is likely to occur in any one who is run down, in arthritis it has always been difficult to decide whether the infection caused the disease or was a result thereof.

Infection is most often found in tonsils, sinuses, gums, and teeth roots, and occasionally in gall bladder and intestines. Anything that can lighten the load of a person with rheumatoid arthritis should be done. Therefore, removing foci of infection helps to improve his general condition, but will not produce miracles. Although infections must be taken into account, they have not proved to be the cause of arthritis. With an increasing knowledge of body chemistry, vitamin and mineral deficiencies, and a greater understanding of psychic factors in arthritis, there is a swing-back from radical wholesale removal of foci toward a more conservative attitude. My own experience has been that infection should be evaluated only after the whole story is known. Sometimes the removal of a focus is safe; sometimes it is dangerous, and it is therefore advisable to wait until the general resistance has been improved. From bitter experience I have learned to be conservative. Ill-timed operations may break down all resistance, and instead of being cured the patient becomes a cripple.

Unfortunately, the sulfa drugs and penicillin have had no effect to date on the course of arthritis. Possibly the new streptomycin may give better results.

### PREVENTION OF DEFORMITY

Prevention of deformity is an essential part of the cure of arthritis, and should go along with the medical care. The importance of this cannot be over-emphasized because a large majority of the usual deformities of rheumatoid arthritis can be prevented if treated early, adequately, and continuously.

The first step in preventing joint deformities is to use one's imagination and anticipate what is likely to happen. Soreness leads to pain, and pain to muscle spasm and contraction, chiefly in the flexor muscles. The time to prevent deformity is when the joint first begins to flex. Rest and complete immobilization then relieves pain, and so the spasm subsides. Fixation for a few days in a plaster cast gives this result. If orthopedic help is not available, put on a light cast in the most comfortable corrected position. After a few days the swelling and spasm subsides, and further correction will be possible. When using casts, constant observation is necessary. After two or three days the cast should be bivalved and taken off, and voluntary exercise started, but only as far as the joint will permit motion. After this, daily removal of the cast for exercise is advisable, determined by the reaction in the joint. There is no danger of ankylosis in using this method. I have never seen anything but benefit come from the use of casts as described.

### SURGERY

There is much that can be done by specialized surgery for the arthritic cripple. Synovectomies, posterior capsuloplasties, arthroplasties and arth-

rodesis can restore a certain degree of usefulness and correct deformities of damaged joints. Reconstructed joints are never as good as where deformity has been prevented. The best results are obtained in knees and elbows. Hands and feet are more difficult. This kind of surgery requires considerable experience in choosing the right case and the type of operation which will give the best results. Many damaged joints can be improved by surgery, and there is no unusual risk because of the arthritis. Many cripples are afraid of surgery, not realizing that operations are increasingly successful.

### ENVIRONMENTAL FACTORS

In considering the surroundings in which an arthritic patient lives, both the physical and mental are important. Is his home well heated and sunny, or cold and damp? Does he dress warmly? Is his place of work detrimental to his health? Since chill, dampness, and exposure are bad for arthritis, often his home and business conditions have to be changed. In some cases a change of climate is advisable. What kind of food does the family habitually eat? Does it consist only of meat, bread, and potatoes, or of fruit and vegetables? What are his habits of rest and sleep? Are they sufficient? If not, how can he change them? We all recognize the value of such questions as these in planning our treatment for any patient, but with the arthritic it is vitally important to correct unfavorable conditions as fast and as far as possible.

The mental atmosphere in which the rheumatoid arthritic lives may determine his recovery. After studying fifty cases, Dr. Walter Bauer found that in 66 per cent there was a direct correlation between the disturbing episodes in the patient's life and the flare-ups of his arthritis. In one-half the cases there was unhappiness and frustration in the home. The percentage in my cases was even greater. I found that the unhappy relationship and consequent fear and resentment came from their selfishness and demand. A burst of temper was followed by a flare-up of the joints. Such emotional upsets would undo all the improvement gained by medical treatment. Some change had to take place in the patient and his home-life in order to prevent these set-backs; otherwise ultimate improvement was uncertain and limited.

This is where the "spiritual history" comes in. It gives the foundation on which to start building a new approach to life. Sometimes the patient, often the whole family, needs a change of heart—a new spirit of cooperation and interest. Even though they may not get well physically, as sometimes happens, with a better outlook on life they fit into their environment better, not as a menace but as a constructive force. After treating people in this way for the last twelve years, I am convinced that homes where there is constant friction should be as much our concern as any other part of our medical treatment. Surely this is preventive medicine at its best. It is appalling to realize the number of unhappy homes in America and the amount of sickness of mind and body they are producing. Such homes are also a grave economic problem to the country. The physician who is sincere and who accepts such responsibility can go a long way in producing harmony in every home he visits, for people heed what their doctor says. He is welcome in their home; he can be friend, father confessor, guide, and teacher. He can help people realize their own selfishness, and thus acknowledge where they are wrong and need to be different. He can guide them to a new understanding of their responsibility in their family life. But in order to guide others, the physician must first have found the answers for himself. Such a physician is a public benefactor in his community. By building moral fibre and spiritual standards in the lives and homes of his patients, he is truly making his greatest contribution to the health of the nation.

### SUMMARY

The important points which I wish to leave with you are:

(1) The arthritic problem in this country is too great for the specialist alone; it requires the cooperation of the general practioners.

(2) Arthritis is a constitutional disease requiring complete and continued treatment from the start. There is no short cut to recovery.

(3) In three-fourths of all the cases of rheumatoid arthritis the prognosis for a useful life is excellent if treated early and adequately. One-fourth of these cases require long hospitalization and reconstructive surgery in the hands of specialists.

(4) The arthritic problem is of national importance, because of the country's enormous monetary expenditure and work days lost. Anything we can do to stop this loss is our patriotic duty.

And now may I add a final thought. In spite of the marvelous advances in science and medicine, there remains the 70 per cent of patients we are asked to treat where there is no organic pathology. These are indicative of the appalling need in the world today for a new spirit. The next great advance in medicine may well be in the doctor himself, when he is willing to assume the responsibility of bringing this spirit to a sick world.

# BRONCHIECTASIS*

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The problem of bronchiectasis has been discussed very thoroughly in many excellent articles. I am not planning to present this subject in great detail, but I do hope to stress a few points that I believe are important. I believe bronchiectasis to be a much more common disease than is usually suspected.

I have been impressed by the number of patients I see who give a history of having coughed and expectorated pus for many years. They say, "Oh, my sputum was examined for tuberculosis and there wasn't any there." Since there were no tubercle bacilli present in the sputum they were not considered seriously ill.

The importance of the problem is really brought home when it is realized that bronchiectasis usually begins early in life, and that people die of the disease or its complications.[1] One must remember that while these people live their life, it is usually not pleasant because of the cough and foul sputum. There is but one cure for bronchiectasis, and that is the surgical removal of the diseased lung or part of the lung. The operation of lobectomy is a safe procedure. This is not realized by many physicians. It is extremely important to know the extent of the disease at the earliest possible time in life. If lobectomy can be done early there is a much better chance for a cure. Also the patients are saved from many disagreeable years. For those patients in whom surgery can not be performed much can be done to make their lives more pleasant.

## CAUSE

It is known that organisms can be introduced into the normal bronchi without producing any harmful effects. However, if they are introduced and the bronchi become obstructed, definite bronchiectasis may form beyond the obstruction. No doubt infection and obstruction, plus atelectasis, play the chief role in the production of acquired bronchiectasis. The majority of patients give a history of having had pneumonia alone, or associated with measles or whooping cough, during childhood. I am not going to take up time theorizing as to the causation, for I am primarily concerned in knowing the extent and exact location of the lesions, and what can be done in the way of a cure for the patient.

## SYMPTOMS

These patients usually give a history of having coughed and expectorated thick, yellow pus for many years. The symptoms have become progressively worse. Many ascribe their symptoms to the cigarette, or are satisfied in thinking that they have "chronic bronchitis." Pus from nasal sinuses dripping into the lungs is often given as the reason for the productive cough. I see these patients at the time of or soon after the acute episode when the bronchi have become obstructed and drainage is interfered with. There is usually a history of having had a number of these attacks previously, associated with an elevated temperature. A large number of these patients give a history of recent or repeated hemoptysis. On questioning them one finds that they have been coughing and expectorating yellow pus for many years, and that they are not concerned about these symptoms. Infection in the bronchi and bronchiectasis are among the most common causes of hemoptysis. It must be remembered that children who cough may be swallowing their secretions.

## DIAGNOSIS

The diagnosis of bronchiectasis can be made only by the introduction of contrast media to outline the bronchial tree. The history, symptoms, and physical findings of rales may make one suspect the disease. A roentgenogram of the chest, showing increased markings toward one or both bases, may further this suspicion. However, to confirm the diagnosis of bronchiectasis a bronchogram must be made. The bronchial dilatations can rarely be seen bronchoscopically, and I do not believe it necessary to do a bronchoscopy in every suspected case. If one is suspicious of a bronchial obstruction or have difficulty in determining just which part of the lung the pus is coming from, a bronchoscopy may be of benefit.

The making of the bronchogram is a relatively easy procedure which can be learned.[2] I first ask the patient to do a postural drainage in order to clear the bronchi of as much pus as possible. He is then given one of the barbiturates one and one-half hours before and codeine a half hour before the procedure. Following this I spray the pharynx with a local anesthetic and apply the same with cotton on a forceps to each pyriform sinus. About two cc. of anesthetic is dropped into the trachea through the larynx. The bronchogram is best done under fluoroscopic control, using a tilt table. The iodized oil is dropped over the back of the tongue, using a long cannula, or is injected through a catheter inserted into the trachea.

* Presented before the Indianapolis (Marion County) Medical Society on March 20, 1945.

[1] Alexander, John: Roles of Medicine and Surgery in the Management of Bronchiectasis, *Ann. Int. Med.*, **XXVI**:565, 1944.

[2] Adams, R., and Davenport, L. F.: The Technic of Bronchography and a System of Bronchial Nomenclature, J.A.M.A., **CXVLII**:111, 1942.

In doing a brochogram it is important to fill the bronchi of all five lobes. To do this properly requires a knowledge of the anatomy of the tracheobronchial tree. One must be sure to fill the middle lobe on the right and the lingula on the left. The lingula is the lower anterior part of the left upper lobe and corresponds anatomically to the right middle lobe. This is important, because in a large percentage of cases having bronchiectasis in the lower lobes there is an associated bronchiectasis in the right middle lobe or lingula. I recently saw a young man who gave a history of hemoptysis and coughing of thick, yellow sputum for the past three years. X-rays of the chest were negative. Physical examination revealed a wheeze over the upper part of the right lower lobe. I did an ordinary basal filling with iodized oil, but failed to discover any pathology. I next bronchoscoped the patient and saw pus coming from the bronchus supplying the apex of the right lower lobe. Iodized oil was injected into the dorsal bronchus through the bronchoscope. X-rays revealed bronchiectasis in the apex of the right lower lobe. I mention this to show how important it is to fill all the parts of the lung.

### TREATMENT

In an established case of bronchiectasis there is but one cure, and that is the surgical removal of the diseased part of the lung by lobectomy or pneumonectomy. This is possible and safe in those patients who are not too old or whose disease is not too extensive. Therefore, it is important that one determine at the earliest possible time whether or not surgery can be done.

Medical treatment alone has proved very unsatisfactory, and, at best, is only palliative. The most effective nonsurgical measure to be employed is postural drainage. It is not enough merely to tell the patients to hang over a high table and cough. One must show them how to do it, and keep after them constantly.[1] It has been my experience that if postural drainage is employed and carefully supervised more good can be obtained by this simple procedure than by the use of other more complicated methods.

The use of x-ray therapy, iodized oil for treatment, repeated bronchoscopies with or without lavage with some magic medicine, or lavage by the Stitt method has little to offer these patients. I have not seen any real benefit from the use of "sulfa" or penicillin in an established case of bronchiectasis. Phrenic nerve interruption, pneumothorax, paraffin filling, and thoracoplasty have all been used and fallen into discard.

A large percentage of bronchiectasis patients have chronic sinus disease, which in my opinion is usually secondary to the bronchiectasis. One can not hope to cure the sinus trouble until the bronchiectasis has been completely eradicated.

It is often said, "The treatment of disease is its prevention." Raia[3] has shown that the case of pneumonia in a child which clears slowly must receive intensive treatment. Bed rest must be continued until all x-ray signs have completely cleared. Proper pulmonary drainage by posture, and, if necessary by bronchoscopy, must be instituted. If such a program is followed it is possible that many patients who would later develop bronchiectasis may be spared from having this dreadful disease. This means that more children having measles or whooping cough should be given chest x-rays. If an area of atelectasis is shown, proper treatment must be instituted.

In considering treatment for bronchiectasis, it is important to know what happens to the patient in whom a diagnosis of bronchiectasis is made and no treatment, or only medical treatment, is given. Roles and Todd[4] concluded that bronchiectasis in patients who receive medical treatment alone is an extremely fatal disease, for out of forty-nine patients, twenty-three were dead and nine totally incapacitated, and of the remainder only four were "dry" five years after the diagnosis was made. Therefore, about 60 per cent, five years after the diagnosis was made, were either dead or totally incapacitated. The reported mortality rates vary, and this is unusually high. However, I would like to emphasize the point that people die from bronchiectasis, and usually before the age of forty. There are a few patients who survive to the sixth or seventh decades. Those who live are not happy. They cough constantly, and the foul sputum makes it unpleasant for any one to live with them.

Up to the present time there is no way of telling which cases will do well if one uses only minor procedures. Therefore, it may be necessary to overtreat a certain few in order that all may be given the opportunity to get well and enjoy life. In my opinion every case of bronchiectasis, whose disease is not too extensive and in whom there are no contraindications because of age or cardiorespiratory difficulty, should be considered for surgery. The younger the individual and the smaller the quantity of sputum, the lower the mortality. The unilateral cases give the best results. A young individual in good condition whose disease is limited to one lobe, or perhaps two, can face the operation with less than a 5 per cent risk. It is certainly not the hazardous operation that it is generally considered to be.

### CONCLUSION

In conclusion, may I again point out that bronchiectasis is a progressive disease which usually begins in childhood. By means of lobectomy there is an excellent chance of completely eradicating the disease with only a slight risk.

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[3] Raia, Antoinette: Bronchiectasis in Children, with Special Reference to Prevention and Early Diagnosis, *J. Dis. Child.* **56**:852 (Oct.) 1938.

[4] Roles, F. C., and Todd, G. S.: Bronchiectasis—Diagnosis and Prognosis in Relation to Treatment, *Brit. M. J.*, **II**:639, 1933.

# PSEUDOMYXOMA PERITONAEI IN A MAN FOLLOWING RUPTURE OF A RETROCECAL MUCOCELE

## With Case History

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It is not the purpose of this article to discuss the literature on the etiological factors and incidence of pseudomyxoma peritonaei, because this has been done so well by a large number of writers. Rather, it is to report a case which is unusual in that the mucocele was retrocecal and ruptured, and did occur in a male.

Chaffee and LeGrand[1] reported in July, 1942, what they believed to be the fifteenth case of pseudomyxoma peritonaei occurring in a man. The author has searched through all the literature available since that time and has found no additional cases. On this basis, it is believed that this will be the sixteenth case reported. A search of available literature, by the author, has also shown only one other reported case of a mucocele located retrocecally. Myers and Rominger,[2] in March, 1944, reported a case of a retroperitoneal mucocele of the appendix, which was diagnosed before operation and was approached through a right kidney incision. Their case, however, had not ruptured, and no pseudomyxoma peritonaei was present. This is believed to be the second reported case of a mucocele being retroperitoneal, and the first case of a retrocecal mucocele with associated pseudomyxoma peritonaei.

There are several findings in this case which make it interesting, and which might contribute to the understanding of the over-all picture of mucocele of the appendix.

### Diagnosis

Much has been said about the preoperative diagnosis of a mucocele. The general consensus is that unless a palpable mass can be found, or a filling defect of the cecum demonstrated by x-ray, it is almost impossible to make a diagnosis. In reviewing the literature it is evident that in a very high percentage of the cases of pseudomyxoma peritonaei the patient's symptoms have been present for a number of years. In the case of an unruptured mucocele of the appendix, symptoms were present in only about 50 per cent of the cases. In many reported cases of pseudomyxoma peritonaei the usual picture is that of painless, abdominal swelling, varying in duration from a few weeks to three years, with loss of weight, exhaustion, and anorexia. The only constant finding, however, is the painless, abdominal swelling. The usual history is that of the patient's having had previous attacks of acute appendicitis over a period of years, for which no operation was performed. In this case the patient reported that he had an attack of appendicitis about six years before admission to the hospital, and another attack about three years before admission. The age incidence also seems to enter into the picture in that most of the individuals are above the age of thirty. Woodruff and McDonald[3] reported a ratio, of females to males, of 1.4 to 1.0. Others have reported a ratio of 2 to 1. The age of our patient was twenty-seven years.

The actual diagnosis of pseudomyxoma peritonaei has never been made, except at the operative or autopsy table. Chaffee and LeGrand[1] reported what they considered to be the third case of a mucocele being diagnosed correctly before surgery. In their case the peritoneoscope was used to make the diagnosis. This instrument would seem to offer a very valuable adjutant for diagnosing this condition in cases of demonstrable tumor. It is questionable, however, whether this instrument would be used preoperatively in cases which simulate acute appendicitis.

In this case the patient had definite point tenderness upon palpation over McBurney's point. There was also muscular spasm and some rigidity present. The patient also had some rebound tenderness. No masses were felt in the abdomen. The patient had some nausea but no vomiting. His symptoms had been present for about six days, but were actually acute for only about six hours. He was taken to surgery one hour after admission to the hospital. The preoperative diagnosis was acute appendicitis. This was based upon the physical findings described, plus a white blood count of 11,000, with 69 per cent polymorphonuclears.

### Etiology

The actual causation of mucocele of the appendix has been explained by most authorities on the basis of stricture or constriction of the lumen of the appendix, following healing from recurrent

* From the Station Hospital, Hobbs Army Air Field, Hobbs, New Mexico.

[1] Chaffee, John S., and LeGrand, Robert H.: Pseudomyxoma Peritonaei in a Man, *Arch. Surg.* (July) 1942.

[2] Myers, William H., and Rominger, Ruth F.: Retroperitoneal Mucocele of the Appendix. *Am. J. Surg.*, New Series. **LXIII**:362-367, No. 3, (March) 1944.

[3] Woodruff, Robert, and McDonald, John R.: Benign and Malignant Cystic Tumors of the Appendix. *Surg. Gyn. and Obs.*, **71**:750-755 (Dec.) 1940.

exacerbation of acute appendicitis. This same effect can be obtained, however, from mechanical action on the base of the appendix, from adhesions, from poor position of the appendix, et cetera. At the time of the operation of this case no actual stricture of the lumen of the appendix was found. It was, however, completely retrocecal, with the usual picture of the appendix being plastered to the ascending colon. This might be enough of an obstruction to create this picture. One of the unusual features of this case was that the appendix was not ballooned in the usual manner of a mucocele, but rather was about the same diameter throughout its course. This mucocele was about 2.5 cm. in diameter throughout its entire length, and was attached to the ascending colon just below the lower pole of the right kidney. The cecum was cone-shaped, extending out to a junction with the appendix, which necessitated a partial resection of the terminal portion of the cecum with the appendix. The mucocele was ruptured at a point about midway of its length. At the time of the operation the mucocele did not seem to be under tension, but approximately four ounces of thick, mucoid material was present in the lateral gutter, which was found as soon as the lateral peritoneal attachment of the cecum had been divided and the cecum reflected upward.

The formation of the pseudomyxoma peritonaei is interesting, because the consensus is that there is a direct implantation on the peritoneum, of cells from the appendix, by the mucoid material which is found free in the cavity. The theory offered is that the lumen of the appendix becomes distended by pressure until it ruptures at some point. With the outflow of the contents some of the cells are carried from the appendix, which are implanted on the peritoneum. Much discussion has been evoked as to the nature of these cells. Some have been described as containing epithelial cells. Rubnitz and Hermann[4] were interested in differentiation between the cases of pseudomyxoma peritonaei which contain epithelium, and those containing no epithelial cells. This also seems to be appurtenant to whether or not the lesion is malignant. Woodruff and McDonald[3] report that pseudomyxoma peritonaei is malignant in 38 per cent of the cases. This figure is probably very close to the actual findings, because many cases have been reported in which the patient died within several years following operation. Others have been diagnosed on the autopsy table. The cause of death is usually that of intestinal obstruction, as a result of numerous cysts and adhesions between the intestines and the involved peritoneum. The eventual outcome of a case of pseudomyxoma peritonaei may depend upon the extensiveness of the areas involved. In this case the pseudomyxoma peritonaei was found to involve the cecum, terminal ileum, and the anterior parietal peritoneum. The parietal wall, in particular, did not or could not have come in direct contact with the contents of the ruptured mucocele, for all of the typical myxomatous material was found behind the cecum. At the time the peritoneal cavity was opened, a large amount of cloudy, serous fluid was obtained, which was not measured. Floating in this cloudy fluid were numerous yellowish brown specks, which was thought at the time to be fecal matter. After a diagnosis of retrocecal appendix was made, the cecum reflected, and the mucocele found, the yellowish specks and cloudy fluid were recognized as being the condition which has been described by so many authors, and sometimes referred to as "frog's spawn" or "fish eggs."

One of the interesting phases of this condition is the relationship between the pseudomyxoma peritonaei caused by a ruptured mucocele in the male, and the same condition originating from a cystadenoma of the ovary. Chaffee and LeGrand[1] have made a rather detailed comparison between the two. One of the important differences is that the condition associated with a cystadenoma of the ovary is probably more malignant than the same condition occurring after the rupture of a mucocele. Ewing[5] has pointed out that ovarian cystadenocarcinoma spreads mainly by peritoneal implants, which has been the accepted theory for the formation of pseudomyxoma peritonaei. But, he also makes the statement that it may extend to lymph nodes, such as the retroperitoneal and the inguinal. Chaffee and LeGrand[1] stated that lymphatic invasion does not occur with pseudomyxoma peritonaei from mucocele of the appendix.

The findings in this case would suggest that possibly the condition of pseudomyxoma peritonaei could be established through the lymphatics of the peritoneum or by direct extension through the peritoneum, such as in the case of the Krukenberg tumor of the ovary in females. All of the thick, heavy, mucoid material, such as is described by most authors as being found free in the peritoneal cavity, was in our case limited to the area as described before—in the lateral gutter, retrocecal, and retroperitoneal. This would seem to present some evidence that direct implantation does not necessarily have to take place.

### Treatment

There is no doubt that the treatment for a mucocele, whether or not pseudomyxoma peritonaei is present, is appendectomy. It would also appear important to remove as much of the myxomatous material as possible while operating in the peritoneum. It is generally recommended that the abdomen be closed without drainage, in order to reduce the chance of contamination of a peritoneum already reduced in resistance. In this case, however, a rubber drain was inserted into the peritoneal cavity before closing. This rubber drain was removed at the end of forty-eight hours. Cases have

[4] Rubnitz, A. S., and Hermann, H. T.: Experimental Appendiceal Mucocele Myxoglobulosis and Peritoneal Pseudomyxoma. *Arch. of Path.*, (September) 1943.

[5] Ewing, J.: *Neoplastic Diseases*, (Fourth Edition) Philadelphia, W. B. Saunders Company, 1940.

been reported in which there was spontaneous rupture of the appendiceal stump. Chaffee and LeGrand[1] reported such a case. The anatomical formation of a cone-like elongation of the cecum, which serves as the proximal attachment of a mucocele in a number of reported cases, makes this occurrence quite likely, unless proper operative procedure is done to secure the end of the cecum. In the case reported, the cone-like portion of the cecum was clamped, and the distal portion allowed to remain connected to the appendix. Care was exercised that there be no infringement on the ileocecal valve. The end of the cecum was then closed with over-and-over sutures, inverting the cut edges. A reinforcing layer of sutures was then placed in the cecum. This was done after the cecum had been separated from the parietal peritoneum and reflected upward. It was apparent that the mucocele could not be delivered; therefore, after the proximal end was separated, a retrograde removal was attempted. The mucocele was about 2½ cm. in diameter, and approximately 15 cm. in length. The mucocele itself was very friable, and broke several times before it could be removed. The entire mucocele was closely adhered to the ascending colon, with the tip at the lower pole of the right kidney. All portions of the mucocele were carefully and completely removed. All myxomatous material was removed. A portion of the parietal peritoneum was excised and sent to the laboratory for pathological study. The patient made a very uneventful recovery, and at the end of two weeks he was participating fully in the convalescent training program.

### CASE HISTORY

Patient was admitted to the Station Hospital, Hobbs Army Air Field, Hobbs, New Mexico, on August 17, 1944. He was a white male, aged twenty-seven years. He was transferred to the William Beaumont General Hospital for x-ray therapy on October 7, 1944.

*Chief Complaint:* Pain in the right lower quadrant, of approximatey six days' duration, with some nausea but no vomiting. Upon admission the patient did not appear to be acutely ill. There was no evidence of shock. There was nothing unusual about the history. The patient did not use alcohol or tobacco, and denied the use of any drugs.

*Family History:* History was negative for hereditary diseases. He had the usual childhood diseases, with good recovery. No serious illnesses were reported, nor any previous operations. The history by systems was negative, except for the following: the patient stated that about six years before the time of admission he had had a rather severe attack of abdominal pain. At that time he was seen by the family physician, and a diagnosis of acute appendicitis was made. He was kept in bed with ice packs, and after a few days the symptoms subsided. After that, however, he had rather frequent attacks of abdominal discomfort and cramping. There was no history of any constipation. About three years before admission he had had another attack of acute appendicitis. At that time the doctor also kept him in bed, and all symptoms finally subsided. He continued to have chronic abdominal pains until about six days before his admission to the hospital. At that time his pains became rather severe, but he did not report on sick call. As the pains continued, they seemed to localize in the right, lower quadrant of the abdomen. About three days before admission to the hospital he began having some nausea associated with his pains. He finally came to the hospital because of the marked soreness in the lower, right quadrant, and what the patient thought was a slight distention of the abdomen. He was seen on sick call, and at once admitted to the hospital.

*Physical Findings:* The patient was a white male, well nourished, who did not appear to be acutely ill. The head was normal in shape and size. Eyes, ears, nose, and throat were normal. Neck was normal. Lungs were clear. Heart was regular; no murmurs. Extremities were normal. Reflexes were normal. Genito-urinary tract was normal.

*Abdominal Findings:* The abdomen appeared to be slightly distended and rather rigid, with marked muscle spasm on palpation. Rebound tenderness was present. The patient was also extremely tender upon deep palpation over McBurney's point. There was no tenderness over the flank or the back. The liver was normal. The spleen could not be palpated.

*Laboratory Findings:* The patient had a red blood count of 3,750,000, with 80 per cent hemoglobin; a white blood count of 11,000 with 65 per cent neutrophils and 31 per cent lymphocytes. The urine was yellow in color and cloudy, with acid reaction; specific gravity, 1.018; albumin negative; and sugar, slight trace.

*Diagnosis:* A diagnosis of acute appendicitis was made, and the patient was taken at once to the surgery.

*Operative Procedure:* The operation was done under spinal novocain, 150 mg. The operation began at 2:52 P.M., and ended at 4:35 P.M. The peritoneal cavity was entered through a McBurney's incision. Upon opening the peritoneal cavity a large amount of free fluid was found. This fluid was rather cloudy, and contained many small, yellowish-brown specks, which were floating within the fluid. At first this was interpreted to be fecal matter, but later in the operation it became apparent that this was the "frog's spawn" or "fish eggs," typical of pseudomyxoma peritonaei. A membrane was found, which has been described by Spivack as an indication of a retrocecal appendix between the terminal ileum and the wall of the pelvis. A quick search failed to reveal the appendix in its normal position. It was noted at that time that the cecum, terminal ileum, and parietal peritoneum over the region of those organs were studded with small plaques and nodules, which gave the appearance of

FIG. I

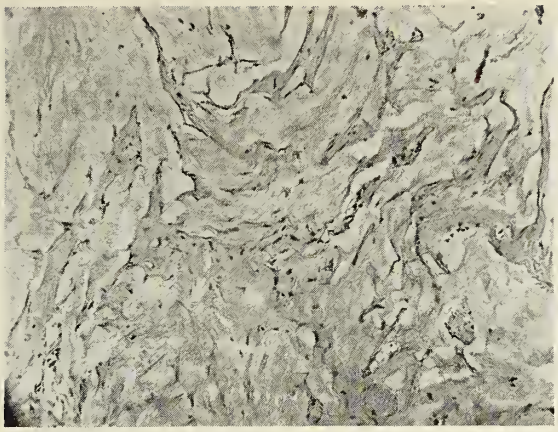

*Figure I shows a representative area of the pseudomyxoma peritonaei, demonstrating the mucinous areas being separated by fibrous connective tissue and dilated blood vessels. Some infiltration with lymphocytes and polymorphonucleors can be seen.*

FIG. II

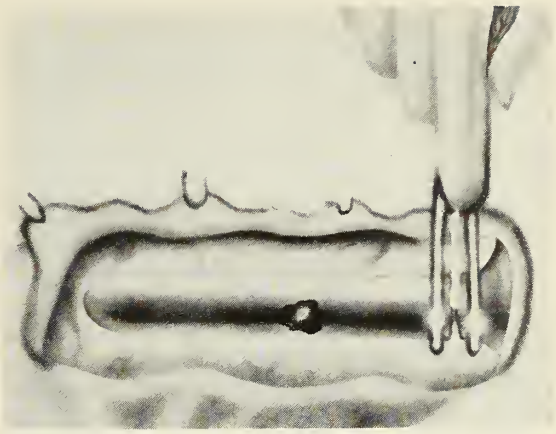

*Figure II is a schematic drawing showing the approximate shape of the mucocele and the location of the perforation. It also illustrates the cone-like projection which was present at the junction with the cecum.*

small, mucous patches. Without further examination the cecum was separated along its lateral border from the parietal peritoneum and reflected upward. The mucocele could then be seen as an elongated tube about 2½ cm. in diameter, and about 15 cm. in length, attached along the ascending colon up to the lower pole of the right kidney. No stricture of the proximal end of the mucocele could be seen. The cecum extended with a cone-like formation to its attachment with the mucocele. The mucocele was removed by the retrograde method. Instead of clamping and ligating the mucocele, the cone-like projection of the cecum was severed between clamps, and the continuity of the wall restored by inverting the cut edge and reinforcing the suture line with another row of sutures. The mucocele was very friable and broke into several pieces while being removed. Before the removal was started, and at the time the cecum was elevated, about four ounces of thick, white, myxomatous material was found in the lateral gutter. A perforation about midway of the mucocele could be seen, from which the fluid had apparently escaped. All such material was removed from the peritoneal cavity. After making sure that all portions of the mucocele had been removed, and the bleeders secured, a small portion of the parietal peritoneum was excised for study by the pathologist. The abdominal cavity was then closed with one rubber drain. Chromic one, twenty-day suture was used throughout. Interrupted dermal was used on the skin.

*Postoperative Progress:* The patient's postoperative progress was very uneventful. The rubber drain was removed at the end of forty-eight hours. The patient was allowed to be up on the fifth day, and began participating in the convalescent program at the end of the second week.

HISTOLOGICAL REPORTS

"Accession No. S-44-1450

"Laboratory: William Beaumont General Hospital. Date: 21 August, 1944.

"*Gross:* The specimen is submitted in two fragments, the larger measuring up to 2.5 cm. in diameter. Each fragment is brownish-black and shows a markedly roughened surface. On section, the cut surface is grayish-black and slightly fragile. No definite markings are seen.

"*Microscopic:* Section shows the fragment to be composed of mucin, the mucinous areas being separated by fibrous connective tissue, hemorrhage, and dilated blood vessels. Occasional areas show infiltration with lymphocytes and polymorphonuclears. Occasional areas of calcification are seen. One edge of the mass shows small clusters of mucous, glandular elements (Fig. I).

"*Diagnosis:* Pseudomyxoma peritonaei.

"Jesse Shapiro, Major, M.C.,
Assistant Pathologist."

"Accession No. S-44-1449

"Laboratory: William Beaumont General Hospital. Date: 21 August, 1944.

"*Gross:* The specimen is submitted in two fragments. One mass measures 1.4 x 1.2 x 0.9 cm. One aspect is rather smooth, pinkish-gray, and glistening. It has the appearance of serous membrane. The second mass is dark, grayish-black and markedly roughened. The undersurface shows several lobules of fat. One area shows a small concave depression, measuring about 7 mm. in size.

"*Microscopic:* Section of the fragment of tissue submitted as an appendix shows the lumen to be relatively empty except for a mild amount of cellular debris. One aspect of the lining mucosa is entirely denuded. Where the lining mucosa is still present, the mucosal glands are markedly disrupted.

Little or no submucosa, in the way of lymphoid tissue, is present. The muscular layers are thickened and markedly edematous, as evidenced by the marked separation of the smooth muscle bundles. There are numerous vacuolated spaces containing light blue staining material. In addition, the muscular layers show a sprinkling of lymphocytes and plasma cells. The serosal surface is not readily identified. Section of the accompanying mass shows it to be composed of large, irregular areas of light blue staining, stringy material, highly suggestive of mucin. There are several collagenous, fibrous septa running irregularly between the mucinous masses. One edge of the mass shows hemorrhage. The entire mass is partially surrounded by fibrous connective tissue, showing lymphocytes and occasional polymorphonuclears. In several of these there are embedded, among the mucin, small dark-staining granular masses, suggestive of calcification. Special stains with carmine show the above-described areas to be definitely mucinous.

"*Diagnosis:* 1. Mucocele of appendix, ruptured.

2. Pseudomyxoma peritonaei.

"JESSE SHAPIRO, Major, M.C.,
Assistant Pathologist."


### SUMMARY

The sixteenth recorded case of pseudomyxoma peritonaei from a ruptured mucocele of the appendix occurring in a man is herein reported.

The first case of a retrocecal mucocele, which had ruptured before operation, is recorded.

No actual stricture of the lumen of the mucocele was found at the time of operation of this case. However, there was acute angulation present because of the retrocecal position.

The possibility is suggested that the condition known as pseudomyxoma peritonaei might be established through the lymphatics of the peritoneum, or by direct extension through the peritoneum, such as in the case of the Krukenberg tumor.

Because the picture of a pseudomyxoma peritonaei caused by a ruptured mucocele of the appendix is similar histologically to that same condition caused from an ovarian cystadenoma, it would seem difficult to determine whether or not the pseudomyxoma peritonaei is actually malignant. With this in mind, it is recommended that all cases displaying pseudomyxoma peritonaei receive roentgentherapy, as suggested by Weaver,[6] as a routine postoperative procedure.

In recognition of the fact that a mucocele and its complication of pseudomyxoma peritonaei, which is considered to be malignant in 38 per cent of the cases, could well be the result of repeated attacks of acute appendicitis, it is recommended that the surgeon adhere to the old adage of removing the appendix whenever a diagnosis of acute appendicitis is made. This also applies to as early an appendectomy as possible in the cases of appendiceal abscess in which the appendix could not be removed at the time of the first operation.


[6] Weaver, C. H.: Mucocele of Appendix with Pseudomucinous Degeneration. *Am. J. Surg.*, **36**:523-526 (May) 1937.

## ABSTRACTS

### JOURNAL ASSAILS PROPOSAL TO CHANGE TRADE NAMES OF DRUGS

Several pharmaceutical manufacturers in the United States are planning to market antibiotic preparations, such as penicillin and tyrothricin, under special trade names, and the October 20 issue of *The Journal of the American Medical Association* warns editorially that the move would only tend to confuse identity of the drugs.

"These agents are among the most active and useful compounds that have ever been developed," the editorial said, adding: "Some of their usefulness will be lost by confusing their identity.

"The phenomenal success of sulfonamide therapy in the United States has been partly due to willingness to make these compounds available under nonproprietary names. When a physician prescribes sulfanilamide, sulfathiazole, sulfadiazine or any other sulfonamide he knows exactly what he is prescribing. Such was not and is not now the case in other countries, where the sulfonamides have been offered under a multiplicity of names. What can manufacturers really gain by abandoning the prestige and publicity that have been given to penicillin and attempting in lieu thereof to establish new names which mean nothing to the medical profession? If their preparations are misused and if antibiotic therapy does not make the progress for which there is promise, these manufacturers must share the blame. The medical profession may well resent these attempts to muddy the clear waters of scientific advancement to conceal a desire for unwarranted individual profits."

### FIND RIGID CONTROL OF SALT INTAKE LOWERS HIGH BLOOD PRESSURE

Rigid control of salt intake has been found helpful in lowering high blood pressure, according to a report in the October 20 issue of *The Journal of the American Medical Association.*

Six investigators—Arthur Grollman, M.D., T. R. Harrison, M.D., M. F. Mason, Ph.D., James Baxter, M.D., Joseph Crampton, M.D., and Francis Reichsman, M.D., of Dallas, Texas—severely restricted the salt in the diet of six patients. The blood pressure in two was reduced to essentially normal levels, while in three others there was a moderate reduction.

The authors, who are from the Department of Experimental Medicine of the Southwestern Medical College and the Medical Service of the Parkland Hospital, state that "the results thus far obtained would appear to indicate that in certain patients this form of therapy is decidedly beneficial."

Although experiments in controlling salt in the diet have been made at different times in France, Germany, and the United States none have so far proved successful. The authors believe that they failed because of the employment of moderate, rather than drastic, restriction of salt in the diet. Moderate restriction, they state, usually fails to influence appreciably the blood pressure.

As yet, the effect of rigid salt control has not been studied during hot weather and the investigators believe that harmful effects may occur when sweating is excessive.

In conclusion the report says that "in view of the relative ease with which this method can be applied, it seems to offer, for certain patients, the most practical and effective therapeutic measure now available."

# ARTIFICIALLY-INDUCED REMISSION IN A CASE OF SUBACUTE BACTERIAL ENDOCARDITIS

MAJOR L. M. SALES, M.C.

Veterans Administration

INDIANAPOLIS, INDIANA

Subacute bacterial endocarditis is by no means a rare condition, and several cases appear each year in the cardiac ward of even a moderate-sized hospital. The percentage of this disease entity, as compared to all forms of cardiac disorders, is given as one to two per cent by most competent authorities, and this figure has shown a slight increase within recent years, probably because of better recognition. Despite this, however, and the fact that numerous chemical and physical agents have been employed, no impressive series of cures has been compiled (although one or two enthusiastic authors have reported exceedingly good results with some particular type of medication, only to have these cases show relapse on further study). Included in the list of various agents tried are: various "sulfa" drug preparations, either alone or in combination with fever therapy; heparin, either alone or combined with fever therapy; whole blood transfusions; arsenicals; intravenous mercurochrome, gentian violet, or other drugs of the flavine series. Of necessity, therefore, all claims for a new remedial agent in this disease must be viewed with a great deal of skepticism and the final decision reserved until its action over a period of years, in a great many of these cases, can be observed, particularly since spontaneous remissions for shorter or longer periods of time are known to occur quite commonly here. However, of late beneficial results have been reported with the use of penicillin, either alone or combined with one or another of the sulfa drugs, and one such case treated by penicillin and sulfadiazine with resultant remission for a period of over twelve months is herewith reported:

The fifty-two-year-old white veteran was admitted to the Veterans Administration Facility, in Indianapolis, on June 8, 1944, complaining of low grade fever of approximately five weeks' duration, associated with progressive weight loss, lack of strength, and generalized malaise. The fever had first appeared, following an intense chill, shortly after the patient had several teeth pulled (at his doctor's recommendation, because of pain, stiffness, and marked limitation of motion of the left shoulder joint, which had been present for approximately four months at the time of admission to this facility). The patient had received treatment prior to hospitalization—liver, iron, sulfa drugs, et cetera, but had failed to improve and had noted, in addition to the symptoms complained of above, the gradual appearance of easy fatigability, dyspnea on exertion, and some pitting edema of the lower extremities (although the latter symptom had been present more or less, off and on, for the past few years). No other C.R., G.U., or G.I. symptoms were complained of, other than for an occasional dull, aching pain in the right lower part of the abdomen, occasional bloating and flatulence, and a history of a chronic prostatitis.

Physical examination disclosed a well-developed, rather poorly-nourished, adult white male who presented some pallor and evidence of recent weight loss, and who appeared acutely ill. No cardiac enlargement was found, but the apex impulse was rather diffuse and heaving in character, and there was a high-pitched, blowing, well-sustained systolic murmur, best heard at the mitral area and transmitted to the left axilla, where it was preceded by a low-pitched, rumbling, and somewhat crescendo, although short-lived, presystolic murmur, and followed by a short and snapping mitral second sound. No other murmurs were audible, nor was there any transmission of the above murmurs to any other valve areas, and the quality of the heart sounds was good, although P2 was loud and snapping in character and definitely louder than A2. The blood pressure was 120/70 in both arms; the pulse was 80, and, aside from some moderate peripheral arteriosclerosis, there were no other significant cardiovascular findings. The physical examination was otherwise essentially negative, other than for the left shoulder joint which appeared more or less immobilized against the chest wall—largely by periarticular spasm. The patient's temperature on the day of admission rose to 101.6°, and for the next seven days of his hospitalization it ranged from 98° to 102°, reaching its peak, usually at 4:00 to 8:00 P.M. every night, and being associated with a moderate tachycardia but no particular increase in respiration. The chest plate showed no evidence of cardiac pathology, but did show some hyperradiolucency involving the upper lobe of the right lung and extending from the apex downward as far as the third rib, anteriorly—this being thought due to some pulmonary emphysema. The x-ray of the left shoulder showed a chronic arthritis of that joint.

Because of the patient's septic type of temperature curve, coupled with an obvious mitral stenosis and insufficiency, the probability of a subacute bac-

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terial endocarditis was considered very strongly, and the patient was worked up accordingly. On June 16, 1944, the patient manifested four or five small petechiae on the chest and upper back—these disappearing in a matter of twenty-four to forty-eight hours, and as of June 15 two blood cultures, taken June 9 and June 12, respectively, were reported as being strongly positive of Streptococcus viridans. The sedimentation rate was also elevated (being 25 mm. on June 9, 1944) and the blood count showed a moderate secondary anemia with 3,750,000 red cells, 11 gms. of hemoglobin, 12,700 white cells, and 70 per cent polymorphonuclears. Other laboratory studies (several urinalyses, sputum examination, Wassermann, N.P.N., stool specimens, gastric analysis, and blood sugar) were all essentially negative, and the E.K.G. showed merely the presence of left axis deviation.

Because of the self-evident diagnosis, the patient was started on penicillin and sulfadiazine—being given 100,000 units of penicillin intravenously in 5 per cent glucose with normal saline at noon on June 17, 1944, and then given 30,000 units intramuscularly every four hours thereafter until noon on June 19, 1944, when the dosage was decreased to 25,000 units intramuscularly every four hours and continued at this level until noon on June 22, when he was cut to 20,000 units intramuscularly every four hours, and on June 23 was cut still further to 15,000 units, being continued at this level until June 25 when the penicillin was discontinued. On June 19, 1944, the patient was also begun on sulfadiazine (at 8:00 A.M.) and he was given an initial dose of sulfadiazine and sodium bicarbonate, $\overline{aa}$ gr. 30, this dose being cut to 15 gr. $\overline{aa}$ every four hours by noon, and being continued at that level until noon of June 22, 1944, when it was decreased to 11¼ gr. of sulfadiazine and an equal amount of soda every four hours until noon June 24, when it was decreased still further to 7½ gr., and at 8:00 A.M. on June 27, 1944, discontinued entirely. The total dosage of penicillin thus given was, therefore, 1,150,000 units. Immediately after the penicillin was started the patient's temperature declined to within normal limits and remained there for approximately twenty-four hours, but on June 19 it rose once more to 100.6°. At that time sulfadiazine was also begun, and following this the temperature declined to normal and remained so for the remainder of the patient's hospital stay (the patient being discharged on August 19, 1944, having, however, had one month's furlough in the meantime and having no ill effects whatsoever while under moderate activity on the outside). A few days after medication was begun the patient did manifest a small and rather tender nodule over the left parietal region of the skull, and another one over the left temporomandibular joint, both of these having the appearance of an Osler's node with, however, some hematoma formation, and both of them disappearing promptly under further treatment, with no further recurrences of either petechiae or of the nodes. The patient's blood count rose to within normal limits (under iron medication), reaching a level of 5,000,000 red cells with 15 gms. of hemoglobin and 12,100 white cells, but only 43 per cent polymorphonuclears and 48 per cent lymphocytes prior to his discharge. The patient regained some range of motion in his left shoulder under physiotherapy, put on weight, and, in general, felt much stronger and was able to be up and about with no symptoms whatsoever, except some slight pitting edema of the lower extremities, and two blood cultures, taken in the latter part of July, were both reported as negative.

Arrangements were made, when the patient was discharged, for him to be re-admitted for a period of study every three months to determine his further progress. To date, he has had three such periods of hospitalization—in October, 1944, and January and May of 1945, respectively. Since his discharge the patient has gained more than thirty pounds in weight, has not noted any fever or ill effects whatsoever, and is able to be up and about, putting in several hours a day at his office with no obvious discomfort, although still experiencing occasional slight pitting edema of both ankles. Furthermore, he has regained much use of his left shoulder, which he is now able to move in a fairly good arc. Physical examination remains negative other than for a persistence of the murmurs previously heard. Repeated blood cultures, blood counts, urinalyses, and other laboratory studies have all been essentially negative, and the patient states that he feels much better now than he has for several years.

The absence of any signs of activity of this patient's bacterial endocarditis in more than a year's period is, to this writer, definitely encouraging, although one must admit that the final outcome is still not certain.

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## ASK DOCTORS' AID IN OFFICE SHORTAGE

To relieve the present shortage of available office space, practicing physicians are urged to share their offices with doctors who are returning from service.

An editorial appearing in the September 29 issue of *The Journal of the American Medical Association* said: "In large communities, such as cities of over 100,000 population, the problem is apparently far more serious than in the smaller areas. In some larger cities physicians are even remodeling old houses into office space. Many a physician whose office is not fully utilized either in the morning or in the afternoon or even in the evening can make available time and space, as well as the use of his own facilities. The least that can be done for such veterans is to make available to them an opportunity to begin the earning of a livelihood at the earliest possible moment."

*THE JOURNAL*

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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DECEMBER, 1945

# Editorials

## Yuletide of 1945

**Let us celebrate the Yuletide with rejoicing and good cheer. Let us celebrate it with a genuine thankfulness in our hearts for the blessings that have been ours to enjoy.**

## THE FRENCH LICK SESSION

The postwar session of the Indiana State Medical Association was an outstanding success, from the point of registrations, interest manifested, and excellence of programs. Some members had some misgivings about the undertaking, since it was held rather late in the year, and on very short notice. Not many weeks before the convention date official notice had been sent out that there would be no meeting in 1945, due to the convention ban by the ODT. So, when this ban was lifted there was much scurrying about, and plans finally were completed for the annual gathering.

French Lick, as always, is a beautiful spot in which to hold a convention such as ours; being far from the maddening crowd, we are in no wise disturbed by outside forces. Traffic noises just are not heard; and when one wants to go to this or that meeting, it is all under one roof, no long jaunts or taxi fares necessary to get there.

And Old Dame Nature, even though she had begun to dress the landscape in winter garb, had left just enough of her former raiment to make things beautiful to behold.

The Cumberland foothills always will be beautiful, no matter whether clad in the brilliant green of spring and summer, the gay colors of the foliage in the fall, or the bright, clean snow of winter—always a delightful place to come and rest. And the weatherman was most kind to us; imagine sitting out on the wide veranda after ten at night without a topcoat or hat—even though we are just about bereft of natural head covering—chatting with a man for an hour, this on November sixth.

Many members came down several days in advance of the convention, thus being well established by the time the big influx began; others planned to remain over the week-end, to rest up after a busy convention period. And service men, both those still in service and those recently discharged, were present in great numbers. Some of them still wore their uniforms, but many were so eager to be in mufti that they wore civilian clothing, not forgetting to don their discharge emblem.

Here and there were impromptu reunions of these service men. Some had not seen their cronies throughout the entire war period; others met up with officers with whom they had been associated in the various camps, air fields, and actual war areas.

And the women—they just would not stay home; they came in droves. We never have seen so many women in attendance at any of our annual sessions in the forty years or more. For the most part they had their own entertainment, plus the activities of the Auxiliary. They ganged up on the annual smoker, which was not a smoker in the actual sense, and just about took over.

The golfers had perfect weather for playing the great Scot game, using the "hill course," which is said to be most sporty; and from the gunshot sounds coming in over the hills outside our window we opined that a few trapshooters engaged in their favorite sport. Brown's continued to be the perfect host for those essaying their standing with Lady Luck, and, all in all, the setting was just about perfect.

Little of medical politics was heard about the lobby and the corridors, probably because the service men have not decided when they will take over, which has long been predicted. Many old faces, folk who for years have never failed to attend a meeting, were missing. To name but one, Dr. W. T. Lawson, of Danville, venerable secretary of his county society, was unable to be present.

As the days went by the Council and the Executive Committee transacted a large grist of business. Reference committees met to discuss the problems that had been referred to them, and the two regular sessions of the House of Delegates, plus an extra session sandwiched in, provided plenty of work for those thus engaged. When President Forster had introduced the incoming president, Doctor Ferrell, he banged the final gavel, and a most successful convention had come to an end.

The election of officers resulted as follows:

President-elect: Floyd T. Romberger, M.D., Lafayette.

Treasurer: A. F. Weyerbacher, M.D., Indianapolis (re-elected).

Delegates to A.M.A. (Term expires December 31, 1947): Don F. Cameron, M.D., Fort Wayne; and F. S. Crockett, M.D., Lafayette.

Alternates: Norman M. Beatty, M.D., Indianapolis; and A. M. Mitchell, M.D., Terre Haute.

Delegate to A.M.A. (Term expires December 31, 1946): A. S. Giordano, M.D., South Bend, was elected to fill the unexpired term of George R. Dillinger, M.D., who resigned.

Alternate: George Collett, Crawfordsville, elected as alternate to A. S. Giordano, M.D.

The following councilors were elected: Second District, James H. Crowder, M.D., Sullivan; Fifth District, A. M. Mitchell, M.D., Terre Haute; Eighth District (will report later); Eleventh District, C. S. Black, M.D., Warren. (The Ninth District reported that Dr. Wemple Dodds, M.D., of Crawfordsville, would be appointed to fill the unexpired term of Dr. Romberger until this appointment can be confirmed at its next district meeting.)

Fort Wayne was selected as the place for the 1946 meeting.

The Editorial Board held a protracted meeting on Tuesday, November 6, to consider plans for THE JOURNAL for the coming year.

No section meetings were held this year because of the limited time in which to arrange the program, a general meeting being held instead, but each section held a short business meeting for the election of officers, which resulted as follows:

Section on Surgery: Chairman, J. Robert Doty, M.D., Gary; vice-chairman, William N. Wishard, Jr., M.D., Indianapolis; secretary, Harold D. Caylor, M.D., Bluffton.

Section on Medicine: Chairman, Marion R. Shafer, Indianapolis; vice-chairman, William M. Dugan, Indianapolis; secretary, Maurice E. Glock, Fort Wayne.

Section on Ophthalmology and Otolaryngology: Chairman, J. V. Cassady, South Bend; vice-chairman, Edgar C. Davis, Muncie; secretary, H. C. Wurster, Mishawaka.

Section on Anesthesia: Chairman, John M. Whitehead, M.D., Indianapolis; vice-chairman, Frank W. Ratcliff, M.D., Lafayette; secretary, Roy A. Geider, M.D., Indianapolis.

Section on General Medicine: Chairman, J. T. Oliphant, M.D., Farmersburg; vice-chairman, Claude S. Black, M.D., Warren; secretary, O. E. Wilson, M.D., Elkhart.

The registration totaled 922.

Thus ended another highly successful meeting. The attendance was good considering the fact that many of our physicians are still in the armed forces; the program was of usual excellence; and our hosts were the best ever.

Comments on the various features of the convention will be found in the following pages under "Convention Notes."

# MEDICAL EDUCATION IN INDIANA

For some time past we have been deeply interested in the problem of medical education in Indiana, not that what is presently being done is not of a high order, but rather that there is much that can be done to bring about a higher degree of efficiency.

During the recent French Lick convention we heard many new angles to this problem, both in public meetings and in private conferences. In every instance the opinion was that we needed a step-up in our present system, making changes the end result of which would place Indiana at the top.

Governor Ralph E. Gates, in his address at the annual banquet, showed that he had been studying this very problem, and proceeded to express some very tangible ideas of what could be done—what must and will be done. One of the many high-spots of his excellent address was when he said, "The old family doctor comes just a little closer than anyone else to the community life of America, and when my term as Governor is ended I want to remember especially that I never let the old country doctor down."

At another point he said, "while five million dollars is invested in the Medical Center, only one million has come from state funds, with the remainder being donated by private citizens." He also reminded his audience—and the citizens of the State of Indiana—that at the beginning of this year the State of Indiana stood thirty-eighth in the matter of public health facilities, then proceeded to state that he would see to it that the incoming new State Board of Health regime would energetically attack this problem, and that Indiana's status in this very important matter will be materially raised.

In other words, as we view the remarks of the Governor, Indiana Medicine has a real champion in the office of the Governor of the State, one who is fully alert to our problems, and one who means to lend every bit of his support in aiding us in what we have been trying to do for many years.

In conference with a medical center official, he made this remark, "The citizens of Indiana are entitled to better medical care; this better medical care can be had only by our making better doctors; the making of better doctors means that we must have better and more equipment at the medical center; and this, in turn, means that we must spend more money on health education."

Certain officials of the state university have remarked that already the costs of operating the medical center are very high; this is, of course, true, if we consider the gross costs. However, let us remember that the state hospitals, such as the Long, Coleman and others connected with the center are self-supporting—their income is sufficient to pay all the operating costs.

We also should remember that during the past four years—the war years—medical education in Indiana has maintained its present high efficiency

in spite of many handicaps, some eighty members of the faculty having been in the armed forces; and the teaching load laid upon the shoulders of the remaining faculty has been very heavy—Doctor Gatch, the dean of the medical school, having borne the brunt thereof through these four years. Yet they have carried on, even with the continuous school program, with an excellent record of efficiency.

Then we come to the address of our president, N. K. Forster, who had something to say on the subject of "Medical Education," and this something is right in line with what we have been thinking for several years past, as have hundreds of other Indiana physicians.

He called upon the membership of the Indiana State Medical Association to support "an early consolidation of the Indiana University School of Medicine into one unit, at Indianapolis," a plan that long since has had the endorsement of the Executive Committee.

Many excellent arguments in favor of such a program are patent, and save for the matter of sentiment, we can think of no cogent reason for continuing the first medical year at Bloomington. THE JOURNAL proposes to discuss this, as well as other matters pertaining to medical education, at much greater length during the coming months, the above being but an outline of the things (as we see them) needing to be done.

Indiana has an unusual setup for medical teaching, what with a faculty of which any medical school should be proud, and with hospital facilities, practically all on one campus, exceeded by no other such school with which we are acquainted. Our big job is to tell Indiana citizens about it, publicize this all over the state, and not forget that we have as one of our biggest boosters the Governor of the State of Indiana.

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## "WAY BACK WHEN"

Dr. Louis H. Osterman, of Seymour, sent us a program of the Mitchell District Medical Society, which he found in some old papers left by his father, the late Dr. A. G. Osterman. We might mention that for many years Doctor Osterman, Senior, served as a member of the Council of the Indiana State Medical Association, and is well remembered for his many activities in that connection.

This meeting was held in Mitchell, December 27-28, 1894, three sessions, including an evening meeting, being held on the first day, and two on the second day. Dr. Joseph Eastman served as president of the society at the time, with our own Dr. Samuel Kennedy as secretary.

The program bears the names of many men known to many of our older members. From Indianapolis, Drs. Theodore Potter, Lewis L. Cline, H. O. Pantzer, J. W. Marsee, and Frederick C. Heath, all of whom spoke on subjects relating to the specialties in which they were engaged. At the time Dr. Marsee was serving as the head of the Medical College of Indiana, while President Eastman was at the head of the Central College of Physicians and Surgeons.

Cincinnati and Louisville were well represented on the two-day program, the guest speaker for the evening being Dr. Joseph M. Matthews, who had chosen the rather unique title for his address, "What Are We Here For?" The following day he had a place on the formal program, speaking on the subject, "Some Suggestions in Rectal Practice."

Frank G. Lydston, of Chicago, a most dynamic speaker at medical meetings in later years was another speaker on the program, as was a well-remembered man from Cincinnati, Dr. P. S. Conner. (Our preceptor, an Ohio graduate, very frequently quoted Dr. Conner, having regarded him as *the* surgical authority of that time.)

The back page of the program carries a full-page ad of the William H. Armstrong Company, of Indianapolis, for many years one of the outstanding surgical instrument houses of the country. They featured "aseptic surgical wool" at the time, which was strongly recommended for tampons. The price quoted was $1.25 per pound. Armstrong also announced that they had issued a six hundred page illustrated catalogue, which would be sent to their patrons on request.

One cannot escape a bit of reminiscence after looking over this old program. Many of the names thereon bring up past memories. Theodore Potter, known to his students as "Polly" Potter, was a pioneer in the study of tuberculosis, being regarded as an authority on this disease. Dr. Louis C. Cline, who for years had an office in the Willoughby Building, the first building erected for medical tenancy in Indianapolis, limited his practice to diseases of the ear, nose and throat. Each year he gave his student class a formula for an antiseptic solution, to be used in nose and throat work, it being quite similar to one of the popular proprietary preparations of the day. There were more than a score of items in the formula, including many of the oils then in vogue in this specialty.

Dr. Joseph Eastman is well remembered by many men still in practice in Indiana. For many years he conducted the Eastman Hospital, at Delaware and Vermont Streets, Indianapolis. His two sons, Drs. Thomas B. and Joseph Rilus later became outstanding successes in the field of surgery.

Dr. Joseph Marsee, later to become Dean of the Medical College of Indiana, was, at the time of this meeting an up-and-coming young surgeon. He was one of the most interesting speakers we have ever heard; he held one's attention throughout his discourse. It was he who when germs, bacteria, et cetera, were first attracting the attention of surgeons throughout the world finally was convinced that there was something to this "new-fangled" notion, and uttered the classic remark, "I do not know that I would recognize a germ if I saw one coming down the street, but I *do* know that once I was blind, and that I now see."

Dr. Frederick Heath, limiting his practice to the eye service, was an Englishman, and as such possessed many quaint oddities. A delightful conversationalist, his company was sought at every state meeting. He was given to attaching rather odd names to some of the eye diseases with which he met, we on occasion having suspected that he invented names for some of these. We recall one instance in which a medical student sought his advice for spells of dizziness. Doctor Heath listened intently to the symptoms as outlined by the student and came up with a title for the condition, naming it "fugacious amaurosis," which he explained as "fleeting blindness."

Dr. Joseph Matthews was a typical "Kentucky Colonel," both in dress and manner, as well as in speech. He used exquisite English, which, with the accent peculiar to his native state, but added to the interest with which he held his audience. Forty and fifty years ago his book on rectal diseases was accepted as the *sine qua non* throughout this country, as well as in foreign quarters.

We have had a good time looking over this old program, noting that they, too, had their medical and surgical problems, even as we have them fifty years later. And it pleases us to know that "way back when" medical men had big meetings with interesting, up-to-the-minute programs, just as we have today. It is those forward movements which have made medicine the most progressive of all the professions.

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## POSTWAR FAKES

Now is the time for all of us to be on the alert, not only shrewd business men, but professional men, housewives, and all. Schemes for separating the public from its money are so numerous that the woods may be said to be full of them. One has but to read the daily papers to learn of new schemes to gull the public, and our Better Business Bureaus are put to it to keep in touch with all of them.

Some of the commercial magazines are gross offenders in such matters, so much so that when a solicitor for a magazine makes his appearance in our office we at once look upon him, or her, with much suspicion. Some of the solicitors are ex-service folk, or at least they represent themselves as such, and some of them claim to represent Army, Navy, and Marine publications, although investigation has shown that these publications have no connection, official or otherwise, with these service branches. And then we have the "working my way through college" group, young folk who put up a mighty story about their future plans, almost to the point of being "sob stuff."

In passing, some of these folk use Social Security cards as a means of identification. We now learn that such cards do not identify anyone, in the sense that the cards may be taken as a reference. It is but a confidential wage record, of value only to the employer and the employee.

One of the biggest frauds, and one of the most dangerous since it appeals to the soft spot of most people, is that of proposing a new home—a home all one's own—a thing that most folk have looked forward to for many years. The "Co-Operative Home Building Companies" have found many people interested in such projects, and that they readily fall for the tall tales put out by the solicitor or the literature sent through the mails. We do not decry the "Co-Operative" idea in any sense whatever, but we do urge that the prospective home builder use every care in investigating the proposal before him.

Only recently, in Indianapolis, and this is happening in every city in the land, a "Co-Op" outfit came to grief via indictment in the local courts. This duo formed a company, advertised lavishly, and began accepting deposits from applicants. The whole thing looked so screwy to the local Better Business Bureau that an investigation was made, and it was found that the "Co-Op" had nothing behind it; no available means of supplying the product it was selling.

Household appliances come in for many swindling groups. We all know just how hard these appliances have been to get, and we also know that the old washer, refrigerator, electric iron, and whatnot needs replacement. So, when we get a circular that John Doe and Company are ready to supply such materials, and that they will accept down payments thereon, we send along the money, then sit and wait, wondering why we never hear any more about the transaction.

These are but a few of the major swindles that are being brought to light every day; the minor ones seem countless. The door-bell ringers, taking orders for small or big gadgets, not costing too much, are increasing in number every day. Then, too, there is the telephone solicitor, rapidly becoming more than a pest; he has become a veritable nuisance. Some chap with something to sell, and too lazy to make the sales in the usual manner, sets up a battery of telephones and engages women to make the calls from that central point. They are trained as to what to say, and their jabber reminds us of that of a parrot. We soon get the drift of the thing, and gently hang up the receiver —we do not get a repeat call from that group!

And, not the least of these nefarious activities are directed against the returning service men. It is known that they have their discharge money in cash, plus other funds that many have accumulated. The railroad stations are favorite hangouts for these small-fry thieves, where they endeavor to "be of service" to returning soldiers, sailors, and marines. This service, if the plan works out, results in the total loss of all the money and valuables carried by the service man. One might go on for a long time naming the various frauds that seem so common in postwar times, but the above will suffice to warn all that we should be on the alert, even to the point of looking with suspicion on practically every such service until its true value has been established.

## "DIPHTHERIA CAN BE ELIMINATED"

Such is the title of an editorial in *The Journal of the American Medical Association*, November 3, 1945. It directs attention to one of the most flagrant cases of dereliction in all health history. Diphtheria, despite our antitoxin, remains a killer, and as such commands our deepest attention. And, diphtheria is preventable by the immunization process which has proved to be practically infallible.

THE JOURNAL consistently has preached "wholesale" immunizations; we have urged that the greatest of publicity be accorded this program, not only by physicians and health officers, but by the lay press.

There are several communities in this country, some of them large cities, where diphtheria is unknown, save in rare instances when a case is "imported" from the outside.

The editorial mentioned, which is printed herewith, directs further attention to the death rate of this preventable disease during recent years, indicating that in the sections where proper publicity has been given there have been but few deaths. We urge that as a part of our program for 1946 one of the outstanding features be the slogan, "Universal immunization of children against diphtheria!"

The editorial follows:

"In 1943 the death rate from diphtheria at all ages fell below one per hundred thousand for the first time. At the same time the death rate in children under ten, in whom the disease is most frequent, has fallen below five per hundred thousand. Wide variation in the size of the diphtheria rates among children occurs, however, in different states: using the average figures for 1940-1942, Delaware without any deaths from diphtheria under ten during these three years appeared at one extreme and, at the other, Arkansas and South Carolina with 13.7 deaths per hundred thousand, and Oklahoma with a rate of 13.5. The available methods for control of diphtheria are sufficient to allow the complete elimination of this disease in the United States. An analysis of fatalities among children insured in a large life insurance company indicated that two factors were principally involved: delay in treatment (when the physician was not called until the fourth day of the disease or later) and the use of insufficient antitoxin. The application of modern immunization methods of susceptible persons on a country-wide basis would serve to eradicate the disease; meanwhile, emphasis on the importance of sufficiently early administration of antitoxin in adequate doses would help to prevent the unnecessary deaths of some one thousand American children who still die of diphtheria annually."

# Editorial Notes

November 8, 1945, marked the fiftieth anniversary of the discovery of x-ray, by Wilhelm Konrad von Roentgen, a German physicist. This event was celebrated by the Radiologic Societies with a banquet held in Chicago. The story of the x-ray is a most interesting one, not only to physicians, but to the general public as well, and will be told in news articles sent out by The American College of Radiology.

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It was with deepest regret that the Council voted to accept the resignation of one of its older members, Dr. H. C. Wadsworth, of Washington. Doctor Wadsworth found it impossible to attend the meeting, and stated in his letter that he felt that the time had come for someone to take over his duties. He had hoped to complete a fifteen-year service in the Council, but ill health has made this impossible. We have known, intimately, of the services he has rendered the state association through these years, and join with his host of friends in the wish for a speedy recovery.

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There has been no little misunderstanding of the ruling of the Executive Committee regarding the resumption of the payment of dues by ex-service men. At the last meeting of that group the matter was clarified. According to the action of the committee, a service man who returns to practice in November, 1945, for example, will not be liable for state dues until January, 1946. If he returns some time between January first and April first, his dues will begin as of the latter date. In other words, there will be no dues for the quarter in which he returns to practice, the dues beginning in the next quarter, to be assessed on a quarterly basis for the current year.

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According to the Gallup Poll, more than seventy-five per cent of our population is in favor of an appropriation by the government of $200,000,000 for the study and treatment of cancer. This shows that the American people are alive to the importance of the cancer problem, and that they want something done about it. After all, the physicians of America are solely responsible for the outstanding knowledge possessed by our folk concerning cancer, this through every form of publicity, including newspaper and magazine articles, radio talks, and personal appearances before various groups throughout the country.

The United Nations Relief and Rehabilitation Administration, in a recent release, states that bubonic plague has appeared in several Mediterranean ports, and that last year the Suez Canal Zone experienced the worst plague epidemic in its history. At Dakar, however, where the plague was rampant some time ago, there has recently been little of this disease. In China, where the population is dense, the incidence of this disease is high, as is cholera. Here these diseases are spreading inland, the source of the infection being the port areas. The UNRRA Administration seems confident that in a few years all these epidemic diseases will be well under control.

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"Pharmacal Information" sends us a pamphlet bearing the title, "When Is a Tomato Not?" The gist of the epistle is that all tomatoes are not tomatoes, in the sense that they do not have the same food values. This has been noted for many years by the tomato industries, who long since learned that certain sections of the country produce the best tomatoes, from the standpoint of food value. This, of course, is the reason why the tomato industries commonly use the phrase "Indiana Tomatoes" on their labels, because Hoosier tomatoes are superior to those of other sections. We all have noted that in the off-season most tomatoes we buy on the markets do not have the real tomato flavor. They are used to add color to our salads, and such dishes, but the flavor is not there, nor the food value. When we want the real tomato flavor, and food value, for dishes such as chili, soups, creole dressing, et cetera, we open a can of Hoosier tomatoes, and there we have it.

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With the Indiana hunting season again open, it would be well for Hoosier physicians to be on the alert for tularemia. Tularemia is no stranger to Indiana and other midwestern states, numerous cases having been reported for several years past. Nor are rabbits to be wholly blamed for the transmission of this disease, which was first described as having appeared in Tulare County, California; dogs, birds, and many small animals, both wild and domestic, are found to be hosts of the tick that seems to be responsible for this infection. In *The Journal of the American Medical Association* of October 13, Drs. Roscoe Pullen and Byron Stuart, both of New Orleans, reported a series of two hundred twenty-five cases of tularemia in New Orleans Charity Hospital, this over a period of sixteen years. Seventeen of these patients died from the infection. One hundred seventy-six of the patients gave a history of rabbit contact, the others naming various other animals, including squirrels, mink, opossum, dogs, cats, and rats. Hunters should be warned not to handle rabbits without the use of rubber gloves.

"DDT," the new insecticide used by the Army and Navy for some time past, is now available to the public, its release having created quite some discussion as to its merits. Much of the complaint is due to the fact that certain manufacturers and dealers are not playing fair with the consumer, in that their solutions are too weak to be of much service. A one per cent solution may be used for the control of one insect group, while it will be wholly inefficacious for another. Our Medical Corps son, recently returned from service, has been spraying DDT solution about the premises, with rather gratifying results. He says he had experience with it in Brazil and that he knows what he is doing—we trust he does!

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According to news releases regularly received from the United Nations Relief and Rehabilitation Administration, that organization continues to function in a highly efficient manner. A recent bulletin, October 9, states that more than seven hundred doctors and nurses are engaged in caring for the two million refugees who have been displaced from their former homes. Another bulletin states that the organization had provided fifty ambulances for the Italian Government. These vehicles were obtained from Army surpluses and have been distributed in those areas where they were most vitally needed. From other sources of information it would seem that the UNRRA is doing a good job in other ways, notably that of disinfecting several areas in Italy, chiefly in hospitals where vermin had become rampant, one of these a hospital in Rome.

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Mention has been made in THE JOURNAL on two or three occasions concerning the Eye-Bank Foundation, in New York City. We are in receipt of further information regarding this most promising institution, from the Executive Director, Mrs. Henry Breckinridge. It seems that a Council of some seventy-five members is being formed, headed by Mr. Albert G. Milbank, who will be remembered as having addressed one of our Secretaries Conferences a few years ago. The plan of the Council includes a research division, together with a school of instruction, where ophthalmologists over the country may further acquaint themselves with the details of this delicate transplant operation. Up to this time it had been found that corneal tissue more than seventy-two hours old is not used very successfully, hence, fresh specimens must be available. These are obtained in various ways, from an eye being removed and in which the corneal tissue has not been injured, and from eyes removed after death. The Council plans frequent communications for the medical press, that those interested may keep in touch with advances made in this important surgical field.

For many years the Indianapolis Medical Society has been considering a permanent home of some sort, the original idea being to purchase some old home near down-town Indianapolis. Later on proposals were made to the Indiana State Medical Association, looking toward some sort of consolidation of the two organizations in the matter of permanent headquarters. Dr. Bert Ellis has been named as chairman of the Indianapolis group, and the Executive Committee of the Indiana State Medical Association has suggested a committee be appointed from that body, these two groups to present some plan for future consideration. The idea is sound if it can be worked out to the satisfaction of both groups, both of whom are already needing additional space, and in future years this need will be greatly increased.

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The matter of discharge from the armed services continues to be a most important subject in medical circles, as is evidenced by a letter from a Lieutenant Commander (MC) of the Navy. He thus addressed THE JOURNAL:

"I note that the Army is automatically discharging medical officers over forty-eight years of age, irrespective of how many 'points' they have. The Navy has no such provision for the discharge of medical officers. This is manifestly unfair. I wonder if you will use your influence to get the Navy to adopt the same rule in 1945?"

We never have been able to understand why the Army and the Navy should have a different setup in the matter of discharges of medical officers, which apparently is the case. This matter is being referred to the Procurement and Assignment Service for investigation.

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In the November issue of THE JOURNAL appeared an account of the Thirty-Second General Hospital that will be given a high place in the history of the Indiana State Medical Association. After a conference with Colonel Cyrus J. Clark and Lieutenant Colonel Charles F. Thompson, Miss Rokke, the assistant editor, compiled the data and wrote the story, this being a sequel to the article she prepared for publication in the June, 1945, issue of THE JOURNAL. It is a coincidence that the first item to come up at our Editorial Board meeting was the proposal by the editor that a story of the Thirty-Second General Hospital be written and published. No sooner had this suggestion been made than Miss Rokke got out the "dummy" for the November issue, and there was the story—pictures and all, already on the press. Finding at the last minute that there was need for a special article for this issue, Miss Rokke had prepared the story. On reading it Tom had conferred upon her the honor of a by-line, which is seldom used by members of the editorial staff, but a privilege we were glad to accord her. We had to admit that we could not have done a better job ourselves!

We are quite in accord with an editorial in *The Journal of the American Medical Association*, of October 20, which assails the plan of certain pharmaceutical manufacturers marketing penicillin and tyrothrycin under special trade names. We have had many examples of just such procedures in years past, and such doings serve only to bring about much confusion to physicians. Penicillin, for example, is just that, and to have different companies put out these preparations under various other names not only would be confusing, but is wholly unnecessary.

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At last it is here; for a long time we have been predicting that one of these days there would be a magazine devoted to "geriatrics." *Modern Medicine Publications*, of Minneapolis, announces that a bi-monthly publication, bearing that name, will be published as of January first. The publishers predict that by 1975 some forty per cent of our population will be in the fifty year, or more, age group; hence, there will be quite a market for such information as they hope to incorporate in that publication. One of our members, Dr. J. B. Maple, of Sullivan, long has been interested in geriatrics, and he believes that in the near future it will be an important specialty in medicine. In a professional card, carried in the Physicians' Directory of THE JOURNAL, Dr. Maple announces "special attention to geriatrics."

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The Health Advisory Council of the United States Chamber of Commerce, in one of its recent bulletins, points out the fallacy in many old beliefs regarding certain food items. It negates the following:

"It is dangerous to drink milk and eat fish at the same meal."

"It is dangerous to drink milk and eat acid foods at the same meal."

"Cheese or milk foods are hard to digest."

"Raw eggs are more easily digested than cooked eggs."

"Milk is fattening."

"Apples (or oranges) should not be eaten at night."

"Fish is a brain food."

The above are a few of the old-timers now being cast into the discard.

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INVEST IN
AMERICA'S VICTORY LOAN!

It's easy to see why the most important Bonds you've ever bought are the Victory Bonds you buy today. Yes—and it's true that you get back $4 at maturity on every $3 you invest on every "E" Bond you own. What counts most, however, is that more than 300,000 wounded need your financial help in a great big way. Buy for *them* in America's Great Victory Loan.

# President's Page

## IN PASSING

During the past year it has been my pleasant duty to prepare a page for THE JOURNAL, and with the completion of this number this duty ends. Naturally, there have been occasions when your own ideas have differed from those expressed on this page, but in every instance the criticism has been kindly, well-intentioned and, I hope, effective. One cannot expect that each month will find universal acceptance of the thoughts registered here, or for that matter that this page will be read by even a small percentage of our members. But we are truly grateful to those who have taken a few moments to read through these lines, and we are indebted to those who have been kind enough to offer suggestions or to voice their opinions. Our aim, in this medium of expression, was and is the attainment of unity of purpose and the application of sound principles for the advancement of our profession and the benefit of those we serve. If an approach has been made toward this goal then I am thankful to you for having given me the opportunity to lend my efforts.

No man ever undertakes an art or a science or any other endeavor merely to acquire knowledge of it. In all human affairs there is always an end in view—of pleasure, honor, advantage, or accomplishment. The finest memory of my medical career will always be the time spent in this office and your kind support in our mutual endeavors to maintain a worth-while organization.

To my successor goes a cordial greeting and the assurance that he will never lack encouragement or confidence in the attitude of the men who make up our association—nor my best wishes for his success. The legacy he inherits is not an enviable one, for truly it is doubtful if ever in the history of organized medicine there has been a time when the spirit of service must play such an important role in our affairs.

The intangibles of medical practice, as represented in our concepts and ideals of service to humanity and the welfare of our patients, are facing obliteration in the strangling grip of socialization and regimentation. Efforts to encompass the tangibles of our economic life are rapidly spreading as the tidal forces of bureaucracy send out more and more engulfing movements. Other problems continue to demand solution. The release of medical officers from the armed forces and programs of assistance in their return to practice; the problem of rehabilitation of the veteran and of the physically handicapped in industry; the energetic programs for physical fitness; the inauguration of prepayment plans for medical and surgical care; the question of provision of adequate hospital and health center facilities—all these are but a few of the major situations confronting medical practice today.

In spite of these economic phases that require so much and such constant attention, medicine has not paused in its rapid strides in scientific progress: the gold of penicillin outcures the remarkable sulfa preparations; syphilis treated in nine days; gonorrhea conquered and non-infectious in a single day; deadly pneumonia laid low in hours; streptomycin, promin, benadryl, DDT, and ANTU provide new promise, and were they not modern medicine they would be miracles.

And, were it not for all these factors offering hope in the present for progress in the future, medicine could not long survive. For the opportunity to lend our efforts in restoring the hope of a new world; for the power and proficiency to aid the comforts of mankind; for the confidence and understanding of those we serve, the medical profession will continue to carry its proud banner of achievement.

N. K. Foster

# AMERICAN MEDICINE*

MAJOR GENERAL GEORGE F. LULL
Deputy Surgeon General
United States Army
WASHINGTON, D. C.

When I came to this meeting I was misled. I was told, "You won't have to make a speech. Don't prepare anything." I haven't prepared anything, but what I will have to tell you is right off the cuff. It doesn't take much of a stimulus to brag about what American Medicine has done in this war. By American Medicine, I mean the state societies, the county societies, and the individual doctors all over the country. This has been one of the outstanding features of the war. Line officers will tell you, from the South Pacific and Europe, "We had a little trouble with some of the services, but the medical service always came through." That was due to the fact that it was put across by American Medicine.

Remember, when the war started there were only about one thousand two hundred officers in the Regular Army. We didn't count. We were a drop in the bucket, because we ended up with forty-five thousand medical officers. The Medical Corps was a cross section of American Medicine. We had the leaders of the profession; we had mediocre men; we had young men out of college, but the job was put across. You have often heard stories that men tell. They write back and say, "Here I am, with nothing to do. I haven't done any work in months." After you get a couple of those letters you figure the Army hasn't done anything. The Army hospitalized 15,000,000 patients during this war. Now, someone took care of them, and took care of them well. In addition to taking care of those patients, the aspects of preventive medicine were taken care of better than ever before. We had no serious outbreaks of any disease in the Army, due to the fact that these were prevented either by planned vaccination, or sanitation, or some other means known to men who did public health work in the Army.

Two years ago, when I was out here, I think I told you what a grand job Indiana had done. Not only Indiana, but many other states have sent the best they had to the armed forces. Now the tide has turned the other way. Everyone is trying to get out of the service. It is a natural thing to have these men in the Army say, "I want to get home, now that the war is over," but remember we have in the United States alone 248,000 patients in our hospitals—that is in the United States alone, not counting the number of patients either in the Pacific or the European theatre. We have done a fine job of evacuating the wounded from Europe. At one time after V-E day we evacuated them at the rate of 40,000 a month, by ship and by air. We are evacuating them now from the Pacific. All the war-wounded who could be moved are back in the United States. These cases are not going to get well in a few days. We have 1200 cases of spinal injury, and it is estimated that 800 of them will never be any better than they are now. There are many thousands of amputees who have to be re-operated, who have to be fitted with prostheses and taught how to use them before they can be turned loose. This can not be done overnight. It is going to take time to do it, and we are trying to discharge the medical officers as fast as we can.

I have a few figures here as of November 2: since V-E day we have discharged from the Army 10,860 doctors. We have discharged 16,479 nurses. So, when the Surgeon General appeared before Congress and stated that by the first of January there would be at least 13,000 doctors released to resume civilian activities, he stated the truth. At that time we were a little nervous about it, but it is going to come through.

There are a great many men who can not be returned to civilian life because they are abroad. Every ship that comes in is loaded down with soldiers and officers. We get a very early priority in the Medical Department, and these men are being brought home as rapidly as possible. Any man who has the criteria for discharge immediately is sent to a separation center for discharge. These criteria, at the present time, are 80 points; or anyone over forty-eight years of age; or anyone who entered the service before Pearl Harbor. Steps are now being taken to revise these points. In numbers, we are perfectly safe. We feel that we can take care of all our sick and wounded with the release of this large number of doctors. The only place that it pinches is in the release of specialists. As you gentlemen know, many of these specialists came on duty early, and many are over forty-eight years of age. If not, they are in the age group where they have one to three minor children, which increases the points. That means that these specialists are eligible for separation, and there are certain specialties that this separation system hurts—orthopedic surgeons, neurosurgeons, neuropsychiatrists—because we still need those men in the service. There are left in the service about 35,000 doctors all over the world. Of

* Presented before the War Participation luncheon of the Indiana State Medical Association, at French Lick, on November 7, 1945.

that 35,000, ten thousand (or almost one-third) are ASTP graduates who have had only short hospital internships. That means that they never were in the practice of medicine. Added to these ten thousand ASTP graduates, we have many more who volunteered early in the war and who came fresh from hospitals and residencies.

There are many things that are being revolutionized at the present time in the training of doctors. The time has come when consideration is being given to decelerating the medical program. The time has come when we have to do away with the 9-9-9 Program which was devised to help out the hospitals. Now we are going to defer ASTP graduates for only one year, and call them all in. There are enough veterans returning from the service to fill all the residencies in all the hospitals in the United States. I say that emphatically, because I have talked to many hospital superintendents who tell me that they have so many applications from veterans for residencies that they simply cannot accommodate them. Men as old as thirty-eight are trying to get residencies in order to train themselves for some specialty.

The movement of physicians in the United States is undergoing a great change. Many doctors who practiced in Indiana are not coming back to Indiana. They are going someplace else; and doctors who practiced in other states are going to come into Indiana. There will be a great shuffling of the medical profession. I can see that from simply looking at the number of cases coming through the office. These men are going to make a change. They want to get away from where they were, for certain reasons. They may have met men in the service who were in group practice elsewhere and who wanted to take them with them. That holds true both ways, so there is going to be a shift of the individuals practicing medicine.

The patients in our hospitals will be concentrated, as time goes on, into fewer and fewer hospitals, so that by June of next year, of the seventy or more general hospitals there will be only ten left. The Veterans Administration has been taking psychotics, a certain number of spinal cord cases, and cases of tuberculosis off our hands. They are the only class of cases we have transferred to the Veterans Administration. All the other cases remain in the Army hospitals until their hospitalization is complete and they no longer can benefit by hospital care. A lot of these cases will be well in three or four months, but, as you know, many of them will still hang on, and they will be a problem. The Veterans Administration could take over the hospitals as we close them, and use them as veterans' hospitals. There are plenty of beds for patients. There is plenty of equipment and supplies, but we are short of personnel. The Veterans Administration does not have the personnel to take care of all these cases, and if we were to allow all of these doctors to leave the service we would not have the personnel to take care of them either. Consequently, many doctors are going to be held in the service, most of them on a volunteer basis. Many of these good men have come to us and said, "Our job will not be done for three to six months. We see that it will not be done, and, although we are eligible for separation at the present time, we feel that we want to stay in until this job is done." That comes from many, many doctors—American doctors. They will not leave until the job is done, and they are to be given a great deal of credit for it, because most of them are making huge personal sacrifices to stay in the service.

I don't know that I have anything else to tell you, except that we are proud of our profession in America, in the way that it has carried on in this war. The death rate for wounded has been cut in half; the death rate in pneumonia has been cut from 30 to 6/10 of one per cent; and the death rate of meningitis has been cut to a small fraction of what it was. You may say, "That is due to certain new drugs." That is true, but the discovery and the utilization of these drugs was a monument for American Medicine.

I am proud to be here with the Indiana State Medical Association, my second visit. I hope that it won't be more than two years before I can return again.

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## PADEREWSKI MEMORIAL HOSPITAL LIBRARY ORIGINATED BY MRS. HERBERT M. WOOLLEN

It is generally agreed that Poland has suffered more than any other country from the ravages of World War II. This is especially true as it concerns the implements of education and refinement. Planned destruction by the Germans of Polish culture included the burning of schools, scientific museums, observatories and libraries, and the killing of all intellectuals. The notorious mass murder of ten thousand officers, including medical doctors, and the casting of their bodies into one enormous grave was one of the early atrocities of the war.

In 1941, shortly after the invasion of Poland, a group of Polish intellectuals escaped into Scotland. Among these exiles were some of Poland's greatest medical men. These men undertook the establishment of a Medical School Army Hospital for Polish-speaking students who were serving in the Polish Army in Great Britain. This group was headed by Dr. A. T. Jurasz, one of Poland's leading surgeons, author of surgical books, and professor of surgery in the Polish Medical School at Poznan before the war. This medical school and hospital was located at Edinburg, Scotland, in buildings of

the University of Edinburg, and was named the Paderewski Memorial Hospital, Dr. Jurasz being dean and professor of Surgery. Funds to equip this school and hospital were provided by the Paderewski Testimonial Fund, Inc., of this country.

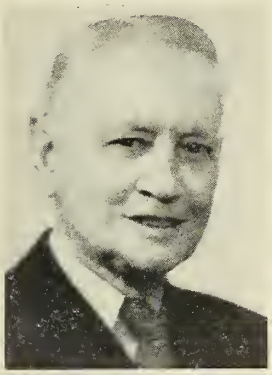
Mrs. Vernon Kellogg is the chairman of this organization, which included as sponsors Mrs. Franklin D. Roosevelt, Mrs. Andrew Carnegie, Mrs. David Starr Jordan, Honorable F. H. LaGuardia, Theodore Meltzer, M.D., Honorable Henry Morgenthau, Right Reverend Monsignor Michael J. Ready, and many others of equal distinction. Herbert M. Woollen, M.D., of Indianapolis, is vice-chairman, and Mrs. Herbert M. Woollen is chairman of the Medical Library Committee.

The securing of books and creating of a library for the Polish Hospital Medical School was a work originated by Mrs. Woollen, and to date she has to her credit a library consisting of 380 new books, 250 books of reference and 200 volumes of periodicals—altogether 830 volumes, given by persons over this and other countries. These books were not gathered promiscuously, but were selected to cover all fields of medicine and surgery by authorities on these subjects. Some of these books were chosen and purchased with the cooperation of the library staff of the Indiana University School of Medicine. In addition to collecting this library by obtaining contributions from many citizens of Indianapolis and other cities, Mrs. Woollen has given substantial financial help. Several hundred individuals have bought from one to ten books each. Eight members of our society have given books.

We believe that this work of international philanthropy by an Indianapolis woman will be of interest to medical men in Indiana.

## INDIANA STATE BOARD OF HEALTH CREATES NEW DIVISION

In accordance with an act passed by the last session of the Indiana General Assembly, the Indiana State Board of Health has created a new division to be known as the Division of Adult Hygiene and Geriatrics, to be concerned with the diseases and disabilities of advancing years. This division is directed by William F. King, M.D., formerly state health commissioner.



*William F. King, M.D.*

Because public health administration, together with medical knowledge and practice, over the past fifty years has so greatly extended the span of life, the number of people living in older age groups is increasing more rapidly than in any other age group. The Indiana State Board of Health believes that through study of the factors affecting advancing age and the application of knowledge now available, or to be made available through study and experience, concerning the diseases and disabilities of age, not only may years be increased in number, but increased happiness and usefulness may be added to these years.

While there can be no fixed or pre-determined point at which maturity can be said to end and senescence begin, yet census facts show how conclusively and dramatically the increase in average age continues with accelerated speed with each recurring census decade.

In 1900 approximately eighteen per cent of the population of the United States had reached the age of forty-five and over. The census of 1940 showed that twenty-seven per cent of the total population were forty-five and over. The Census Bureau, by projecting the present trends in population age to the census of 1980, predicts that in that year those of forty-five and over will constitute more than forty per cent of the total population. The number of men and women in the State of Indiana who today have attained the age of sixty and over is in excess of three hundred and fifty thousand. The number in this age group in the continental United States is estimated at above thirteen million. Within the last census decade, 1930 to 1940, there was an increase in the number of persons sixty-five years of age and over of thirty-five per cent, while in contrast the total population increase was but seven and two-tenths per cent in the same period.

The implications of these statistical facts are obvious. The aging are here in numbers that will not only continue, but will increase both in number and proportion in the years to come. The factors affecting age, either favorably or adversely, and the problems involved in advancing years of life are of immediate concern to everyone. How to maintain health through maturity and into senescence; how to employ wisely and efficiently the changing capacities of those past the meridian of life; how to anticipate and minimize the diseases and disabilities of advancing years; how to provide and assure the best of protection to those whose life contribution and life experience entitle them to the best—these constitute some of the primary objectives of the new Division of Adult Hygiene and Geriatrics.

To be concerned with factors of aging and with problems of the aged is a relatively new and untried activity of public health administration. If all elderly people were healthy and vigorous the immediate social and economic problems involved in the dramatic increase in that part of our population would be greatly simplified. Either the increasing group of elderly people must remain usefully productive, with continued capacity and opportunity for self-support, or the proportionately decreasing group of younger people must support them in one way or another.

# POSTMORTEM EXAMINATIONS

LEROY E. BURNEY, M.D.
State Health Commissioner, Indiana State Board of Health
INDIANAPOLIS

The loss of a member of one's family is at best a tragic event. In order that the loss shall be felt as little as possible, under the circumstances, it is customary for families to go to considerable expense in "putting the loved one away." The family wants the corpse to look as natural as is possible, and for him to be surrounded by such evidence of regard as will seem to satisfy the feeling that "everything possible was done." Out of this very natural desire has arisen the practice of many expensive customs, which may be too expensive for the common good. Whatever may be said about the expense or the advisability of such customs, just the same we do have these customs, and they must be observed. It is better from a health standpoint that the body be embalmed, to be sure, but even if it were not better we would still want this service for the loved ones of our families. Such being the case, it is the duty of the physician to do everything possible to help the embalmer in his art and practice.

The requirements of modern medicine also make it advisable that we do postmortem examinations when there is a reason to question or ponder about the diagnosis. At best, a postmortem examination is a gruesome operation performed upon the body of one who is very precious, and at a time when the emotional wound of the family is still fresh and raw. Here we have a conflict between the science of the medical man and the emotions of the family. Which must be expected to give way to the other? Both must give way to some extent, and both must be respected insofar as that is possible.

A complete autopsy—viscera, brain, spinal cord, bone marrow—is rarely necessary. Partial examinations will commonly fill all requirements except those which seem to demand that every conceivable possibility be considered. A small incision might answer the question as to whether there was a malignancy of some vital organ. In any case, the family has the right to know what is expected to be the scope of the examination which is to be made, and whether the setting of the postmortem room is one of dignity and respect. It is necessary that consent be secured to perform such an examination, except in the case of a coroner's autopsy. The scientifically-minded physician should remember that the body belongs to the family, according to law, and that he, the physician, is asking for a privilege rather than conferring a service. He would hardly be expected to send a bill for such an examination unless the family has requested that a postmortem be done to satisfy its own mind on some point, either medical or legal.

The physician is hardly within his rights if he brings pressure in some way upon the family in order to coerce them into signing an autopsy. We must remember that society as well as the family has rights in such a matter. It is perfectly true that the dead can serve the living in teaching pathology to those who need to understand pathology, and in checking the diagnosis made in the presence of disease which may be quite baffling. We believe that families should permit autopsies when such an examination is likely to be of use in saving the lives of others. It is just that we want to *keep* such a privilege rather than lose it as a result of abuse on the part of those whom the public has learned to trust.

There are almost as many methods of doing a postmortem examination as there are men who do them. Certainly, the body should be treated with respect; it should be kept covered as regards the genitalia if there are spectators in the postmortem room. The family has the right to demand decorum among those present. The features must not be marred; the circulation should be preserved when possible, and when that is impossible the vessels should be tied off so that the embalmer can be assured of the opportunity to practice his art under reasonable conditions. The organs should be replaced in those cavities from which they came, and the closing incision should be of a workman-like nature. Unnecessary mutilation of any sort should be most carefully avoided.

If we of the medical profession are to expect the cooperation of the embalmer or undertaker, we must do everything that is reasonably necessary to help him. We should either be prepared to do the postmortem examination very promptly, preserving the circulation insofar as that is possible, or we should be willing to do the examination after embalmment, which is, of course, rather unpleasant because of the formalin, and not as good from the standpoint of understanding the pathology. The undertaker should not be expected to wait hours for the body, which makes it increasingly difficult for him to get good fixation and color. When a postmortem examination is to be done, the undertaker should be informed so that he will know when to come for the body. With such cooperation the undertaker should reciprocate in every way with the physician in concealing unpleasant incidents which would worry the family and endanger the professional reputation of the physician. After all, he lives in the neighborhood and may easily profit by the high regard of the medical profession; his life might be saved by what the enlightened medical profession learns from a given autopsy.

The family, even in its grief, should feel some obligation to society and be willing to permit such an examination provided there is real reason for it, and providing the human body is afforded the respect which is its due in any civilized community.

# Convention Notes

The dispatch with which President Forster conducted the meetings surpassed anything we have ever seen. "Nes" is a man of few words, but when forced into a state of thought he becomes a man of action, and really gets things done.

Some provident soul provided a new feature at this convention, that of having a party preceding the meeting of the Executive Committee. And lavish was that part of the program—so much so, in fact, that doctors and their wives, on their way into the main dining room were side-tracked, detoured if you please, into the Blue Room. The traffic got so heavy that it resembled nothing so much as a Normandy invasion.

The hotel, as usual, had provided splendid music for the occasion; the young man at the Hammond organ is a high class musician, and offers a versatile program. Just how he manages to play the organ with one hand, the other manipulating the keys of a nearby piano, is more than we could figure out. In addition, there was a splendid orchestra present, playing both in the lobby and in the main dining room. Their programs included both the classical and popular types of music.

*Left to right: Dr. Elmer L. Henderson, Dr. Larue D. Carter, and Major General George F. Lull.*

Just a word or two about Floyd T. Romberger, now that he has been unanimously elected as President-elect of the Indiana State Medical Association. We have known Rommy through all the many years of his activity in Association affairs; at times we have disagreed with him, as he has with us, but a final analysis of our several controversies have indicated that he had "both feet on the ground" on every such occasion. His first official connection with us, other than his annual membership, was as a member of the House of Delegates in the 1925 session, at Marion. We well recall this young chap at that time, because of his intense interest in what was going on; it was a new experience to him, and he wanted to get it all, which he did. Personally, we are highly pleased that he has accepted this advancement, after a long service in the Council, which he had headed for many years. We predict that during the coming year, when he will be acting somewhat as a "sit in," he will make an even more intense study of Association affairs, and that when the gavel is turned over to him, in 1947, he will be fully alert to the big job that is before him.

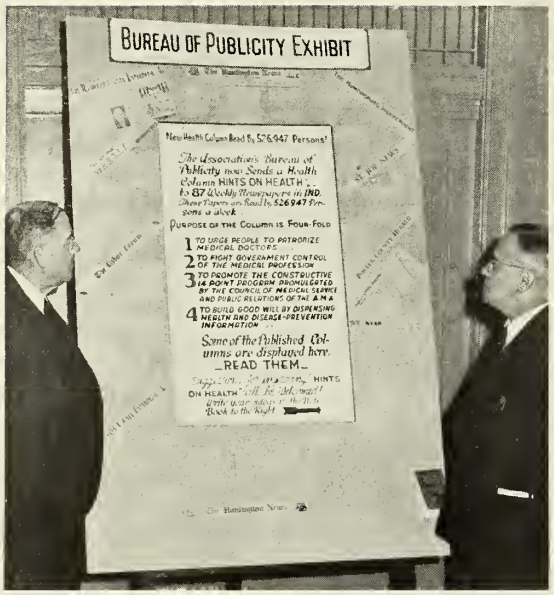
The White County Medical Society had an enviable attendance record at this meeting, exactly two-thirds of its members being present—Drs. Gable and Gryce. However, it might be well to explain that the total membership in this county is just *three!*

Rogers Smith, back from a several months' stay in the South Pacific area, was on the job, full of the old U and A (urea and acetate, for those not in the know.) On Tuesday night he and the Missus were flitting about from room to room, not missing a thing. Rogers has an "ear" for the tinkle of glassware and can ferret out an impromptu party.

In a corner of the lobby we saw George Daniels, venerable past president from Marion, and W. E. Amy, of Corydon, in a close huddle. Barging in upon them we learned that they had under discussion the subject of old-time therapy, claiming that the younger set knows nothing about the drugs that have been faithful companions of the oldsters through the years. Amy, by the way, is serving his thirtieth year as delegate from Harrison County, a long enough service to warrant a medal from his confreres.

The doctors of the local and district medical societies in the French Lick territory deserve a huge salvo for the manner in which they planned and conducted a most satisfactory convention. From personal experience we know somewhat of the problems to be met in such an undertaking. Both Doctors Boyd and Hauss, as co-chairmen, must have put in many hours in planning all the details for the meeting, while Doctor Buckley evidently used reams and reams of paper in figuring out all the details of the entertainment program, chief feature of which was the "Hoss Racin'." However, we understand that this chap is a product of Kentucky—at least he is a graduate of one of its former medical schools; hence, it might be expected he would retain some of his one-time knowledge of horse flesh and its possibilities.

The hotel had a capacity crowd, and at times the dining room was so jammed that one had to take turns. However, with the end of the war the management has been able to get more help, so things went along very smoothly.




*Dr. Jesse E. Ferrell and Dr. Floyd T. Romberger.*

The Bureau of Publicity exhibit at the annual session of the Indiana State Medical Association, at French Lick, in November, attracted the attention of Dr. Jesse E. Ferrell, of Fortville, the 1946 president (left), and Dr. Floyd T. Romberger, of Lafayette, who was named president-elect at the meeting.

The display consisted of clippings from the eighty-seven weekly newspapers which are receiving the "Hints on Health" column each week. Estimating three readers to each paper, a total of 526,947 persons are reached through these columns weekly.

"Hints on Health" is an additional news release established by the Bureau in September. Its purpose is to dispense health and disease-prevention information, and, incidentally, to boost the constructive program of the medical profession.

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Many of the oldsters regretted the passing of the old-time "smoker," the one occasion when the men would get together, drink a modicum of Gambrinic nectar, "keg beer," as Ferd Weyerbacher calls it, and have a general "gabfest." One of these days some enterprising entertainment committee is going to put on just such a show, and we predict that it will be a wow!

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The House of Delegates took time to pause in its work, and stood in silent tribute in memory of those of our membership who have passed on during the past year.

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We've known a lot of folk connected with our state meetings over a period of more than four decades, have watched them in action over the years, and could properly catalogue most of them. Of the entire group, covering several thousand in that long period, we, without hesitation, give the palm to Tommy Hendricks as the chief will'-o'-the-wisp' of the entire flock. No matter what committee meeting he is supposed to attend, he is an "in-and-outer." About the time the chairman of the meeting wants some information, which must come from Tommy, that chap cannot be found; he just disappears, and shows up some time later. Never saw anyone like him.

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Ray Smith, assistant executive secretary, and general handy man, is getting onto the ropes in good fashion; in fact, he has had somewhat of a promotion—for some months after he came with us he was sort of a "call boy." Remember when railroads had such an "official," whose duty it was to call crew men for trains? Well, Ray did that for some time, forever calling someone or asking where that someone could be found. Now he has *real* duties to perform, at times even handing out sage advice as to how things best can be done. Don't worry about Ray, he is a "comer" and will take care of himself.

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We regret to record that George Dillinger, long-time wheel horse in Indiana Medicine, has decided to become a "Georgia Cracker." For the duration, George has been in the Medical Corps, for the most part stationed at Atlanta, and it now becomes apparent that he has become intrigued with that state, and plans to make it his future home. For many years he has served as a member of the A.M.A. House of Delegates, and it was apparent that the giving up of this honor was no small task for him. Then, too, we lose his most estimable wife, Margaret, who for many years has been active in the Auxiliary. We wish the Dillinger family the best there is to be had in all the South, and trust that they will drop in on their Hoosier friends frequently.

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*Left to right: Lieut. Col. Glen Ward Lee; John R. Newcomb; W. D. Gatch; and Matthew Winters.*

*Louis W. Spolyar; Haven Emerson, of Columbia University; and Leroy E. Burney.*

*Norman M. Beatty; Roy Lee Smith; E. Rogers Smith; nnd Foster J. Hudson.*

Elmer Henderson, of Kentucky, member of the A.M.A. Board of Trustees, made his usual appearance at the convention. He rarely misses one of our meetings, which this year was held almost in his backyard, he hailing from Louisville, a suburb of French Lick.

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Nes Forster did a swell job, to use one of Tommy's favorite expressions, in the handling of the affairs of the House of Delegates, as well as presiding over other sessions of the convention. For example, on the "insurance question," which has been the subject of debate for some years, Nes used his gavel very effectively, just when it needed to be used, and the matter finally came to a conclusion. All through the House session the move to "lay it on the table" was frequently heard, each time some delegate essaying to continue the discussion before the House. "A motion to table is not debatable," roared the stentorian voice of the gentleman from Hammond; down came the gavel, and that was that.

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There was much mourning and wailing Wednesday morning, at breakfast, chiefly among the women, anent their losses at the "horse races" the evening before. This was a new stunt, and one that seemed to appeal to most everyone.

*Seated, left to right: W. J. Fuson, Russell Sage, Myron S. Harding, Earl H. Hare, Minor Miller, Foster Hudson, Roy Lee Smith, H. A. Van Osdol, William C. Heilman, C. C. Bitler, Frank D. Martin, and Ernest Rupel.*

*Standing, left to right: C. A. Stayton, Otto H. Bakemeier, Edgar C. Davis, Roy V. Myers, O. T. Scamahorn, Norman M. Beatty, Lyman T. Rawles, Colonel Don G. Hildrup, and Robert E. Jewett.*

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George Cook came down from Hammond to help make the wheels go 'round. We thought we might meet up with the whole Cook tribe down there, but it seems that Naomi dropped off at Terre Haute. The twin sons, both rather recent graduates in medicine, are busy in their internships, Tom being at the Indianapolis City Hospital, while Jim has a Fellowship in Medicine at the Mayo Clinic.

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Lake County, probably as the specific result of an order by Nes Forster, had an unusually large delegation on hand, cheer leaders and everything. The cheering was due to another order, to the effect that when he made a pause in any of his numerous speeches the Lake County gang was to start the applause. It worked out beautifully, and the Lake Countyites expect some encomiums from Nes, once they get back into the State of Lake.

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The editor vowed that he never threw, in trust to fortune's chances; yet he couldn't renege, when he passed the slot; dropped in a quarter, and hit the jack pot. Imagine his astonishment as the eighteen bucks rolled out! (Not by the editor.)

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A lot of convention goers miss one of the most important events of the entire trip, that of early rising, to see what goes on when French Lick "gets up," say about 5:00 A. M. Of course, at this season it is quite dark outside at that hour, but in a few minutes one is rewarded by the notes of the early bird, the chap that does not wait until sunrise to send forth his early matin. Tuesday morning there was one little tyke that began his morning "sing" real early. Not one ray of light to be seen in the eastern or southern sky, yet this little fellow was singing at the top of his voice, probably trying to awaken his mate. We did not identify the songster, since it was too dark to see anything outside, but we wafted a little vote of thanks in his direction for the early morning salute.

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One of our agents overheard a woman declare, "I am disappointed; I have seen very few new coats down here." Bless you, lady, there were plenty of these around, but the weather was such that even at night there was little occasion to wear a coat.

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With a shortened scientific program—there were no section meetings this year—and with the main session of the Council set for the breakfast hour, we had more time for our editorial duties than is usually the case at these meetings. We were able frequently to slip off to our quarters 'way back in the woods,' get out our little portable, and go to work. As a matter of fact, practically all of our convention writing was done right on the job, rather than waiting until we had returned home, where we probably would have forgotten about many items we had thought worth putting in print. An additional aid was the fact that both Nella and Reba were right on the job, grabbing copy right off the Royal, and doing their own editing. (Yes, we might as well admit it, our copy undergoes close scrutinization at the hands of these two valuable assistants, neither of whom is a bit backward about changing a lot of the things we write, just as they do the material sent in by others.)

This concerns two who didn't get there, but whose intentions were good. Dr. Paul M. Gray and Dr. Harold S. Brubaker, of Huntington, started out early Wednesday morning in a two-seat Piper Cub cruiser for French Lick, to attend the convention. The two air-minded physicians got as far as Indianapolis, when strong headwinds forced them to abandon their plans and wing it back to Huntington. Dr. Gray said, "All indications were that the headwinds encountered resulted from increased air pressure arising from the French Lick Springs Hotel." Could-a been!

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Paul Tindall, from Shelbyville, apparently never forsakes an old habit. Some twenty-five years ago, when we were associated with him on the old Indiana State Board of Medical Registration and Examination, we noted his fondness for sliced cucumbers, sans salt, pepper or vinegar, and mashed potatoes. The other morning we stopped at his breakfast table, and there he was, sitting before sliced cucumbers and mashed potatoes, along with a lot of other things. The "cuke," by the way, was a product of Davis, of Terre Haute.

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For the first time in many years at our annual session we failed to see any striking, unusual creations in hats—men's hats we mean. Maynard Austin usually shows up with some new feather adornment on his chapeau, while "Bunny" Hare, of Evansville, can always be counted on to wear some outlandish model. Austin said that due to the recent shortage of chickens he was unable to find a suitable feather; while Hare did not show up at all, so far as we could learn. May be that these old-timers are just being their age, and have cut out all attempts to appear youthful.

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One of the joys attendant upon attending a state medical convention at French Lick is the getting there. Years ago most of our meetings in this section of the state were held at West Baden, back in the days when train travel was necessary. We thought nothing of spending a whole day in coming down from Lake County, chiefly because we had a lot of company. At most every station we had additional reinforcements, and when we arrived at Roachdale we picked up a vast horde from Indianapolis and points thereabouts. Many came from that section via a Pennsylvania-Monon hookup. But as of today there are practically no trains to the beloved spot, hence, the jaunt by car is a *must*. However, as we get pretty well down in Indiana we forget the tedium of such a journey, for Dame Nature has done a splendid job of making the flitting landscape something to look upon. Sounds like a plug for Tom Taggart, but we *do* like French Lick; each time we approach the hotel we find something new to admire about it and its setting. We hope to attend many more conventions in this beloved spot.

The elderly Negro in charge of the Pluto bar, on the lobby floor, continues to be the same old-time philosopher we have known him to be for many years past. This time he made the observation that his business was not as brisk as in former years, that guests somehow or other seem to do considerable drinking, but drink something other than Pluto.

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This is a story about Floyd Romberger, the genial and efficient chairman of the Council: By diligent and persistent inquiry during the dinner preceding the meeting of the Executive Committee, we got his life history. As we long had suspected, "Rommy" is a "Pennsylvania Dutchman," transplanted to Lafayette, Indiana, some twenty-six years ago. He still can speak that language, as well as a passable German tongue, and since many Pennsylvanians reside in the territory contiguous to Lafayette, notably Mulberry and Rossville, he finds it mighty convenient in his work. Romberger is a philosopher of a different type; his views of the thing we call "life" are interesting. He is reaching the reminiscent age, and likes to talk about "way back when," although to us many of his references have a most modern tinge, because of the disparity in our ages. We had a long chat, and as usual we enjoyed every minute of it. (Later he was chosen as our next president, to lead Indiana Medicine in its forward march.)

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Here's our annual story about our gals, those from Hume Mansur, up Indianapolis-way (we will discuss them in order of their seniority of service, not ages):

Lucille Kribs continues to answer all the "where is it?" questions propounded by Tommy Hendricks, no mean job, that; never knew a man who could think up all the hundreds of items he wants to take to the annual convention, then forget just where they may be found.

Elsie Reid, a living gazetteer of the membership of the Association, takes control of the registration desk, and when a doctor announces that he neglected to bring his membership card, Elsie just nods to one of her assistants, "alright, he is a member." In addition to this important job she has a lot of details that would worry the average assistant no end.

Then we have the team from the office of THE JOURNAL. Nella Rokke knows all the answers, and can hand them out just like that. Nothing pleases her more than to get the Editorial Board penned up in some room, there to tell them just what has been done, and what they are going to have to do next year. That gal can think up more stuff to put on the agenda than any other person we know, save Tommy Hendricks—he is the world's bet, no foolin'. Reba Stanley, that "information please" gal in THE JOURNAL office was constantly on the alert to pick up news items or changes of address from the members.

Another of the old-timers—yet not so old—whom we were pleased to greet, was Mrs. C. K. Rowlison, who for several years assisted Miss Hope Toman in JOURNAL affairs, back in the days when "Miss Toman," as she was known to almost everyone in Hoosier Medicine, was the Big Boss of our magazine. Mrs. Rowlison was "taking" the proceedings of various committees and formal meetings. Mrs. Waterbury, who is connected with the State Procurement and Assignment Service, also was present for the meeting.

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Those piercing, penetrating screams coming from the Convention Hall, Tuesday night, where the alleged smoker was being held, did not come from a gang of "Bobby Soxers" listening to a Frank Sinatra program, but were the "come on, you!" calls to their favorite horse during the races. We were advised that the mutual sale to the women were about six times heavier than those to the men.

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Most of the members never had heard about it, but for the past few years there has been a three-cornered squabble between Ferd Weyerbacher, the Executive Committee, and the management of THE JOURNAL, over a paltry three thousand dollars. Ferd long has maintained that we owed this sum, a statement we never would accept as being true. At the meeting of the Executive Committee the matter again came up, and, we thought, had been settled in our favor. Not so; it seems that under the medical law and custom it was necessary for the Council to pass on the matter, which they did the next day. Then we were advised that both the Council and the Executive Committee had decided that THE JOURNAL did not owe anybody anything. THE JOURNAL long ago had determined that the alleged debt should not be paid!

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Nes Forster came barging into the dining room on Tuesday, soon after noon, urging Ethel to hurry, stating that he had just forty minutes to get over to the convention hall to open the first session of the House of Delegates. We trailed him over there, and sure enough he was on time, gavel in hand, but no one else was there. As a matter of fact, it was some forty-five minutes later when he banged down the gavel and declared the House to be in regular session. When he gave out the list of reference committees he learned that there were a lot of absentees, and that only about half of the committee chairmen were on the job at that time. Most of them straggled in later on, but too late to appease Nes. Those of us who know him best have long since learned that when he is perturbed a few of the remaining red hair, well back on his head, begin to bristle up. On this occasion every one of the few remaining hairs was doing a "stand erect" order, which meant that Nes felt that a man who took a committee assignment should be on the job when the bell rings.

Until we saw the Official Program for the racing held in Convention Hall, we did not know that so many Hoosier medics had gone in for the "Hoss Racin'" game, as owners and jockeys. For example, the first horse listed, "Ether," sired by "Drop out of Can," is owned by staid old Floyd Romberger, pillar in our Association. What chance could a horse have of winning when owned and ridden by anesthetists—we note that Russell Kretsch, of Hammond, did the jockeying. To make failure certain, Romberger did his own training. Minor Miller was listed as the owner of "Caruncle," "Out of Meatus," trained by E. O. Nay, and ridden by L. H. Bear. Forty-eight horses, owners, trainers, and jockeys participated in the program; hence, we cannot list them all.

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One couple who drove down from Lake County was so entranced by the beauty of the hills up around Shoals that they went back there the next day, wandering over the bluffs and gathering up about a half bushel of walnuts. The young medic remarked, "If I were certain I could make a living back in those hills, I sure would move right down there—never saw such a beautiful spot in all my life." This, notwithstanding the fact that he has been all over the western mountains, and had spent a year in army service, in Brazil, where he had seen plenty of rugged country. We often wonder if southern Indiana residents really appreciate all the beauties of nature that they have right at their front and back doors.

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In all the years we have been going to state conventions down in southern Indiana, we never had stopped at the Spring Mill Park, the only one of the state parks we have not visited. And we have missed a lot, as we found out when we detoured on the way home and spent a few hours in that lovely spot. We did not know that the type of trees they have down there still stood in Indiana. We were sorry we did not have the time, nor the energy, to take a hike through the woods to see what variety of timber they have down there. We spent some time looking over the village, and in one cabin we found a woman doing a bit of weaving on an old-time loom, bringing back memories of the time when such sights were common in Indiana, most every country home having a "loom house," as they were called. But the "mill" was the most interesting thing to us; other than the huge water-wheel, the building was quite like that we knew as a lad, at Wildcat, the upright cross-cut saw and all. We had quite a chat with the miller about the "upper and nether stones," how they were dressed, et cetera. We learned one thing about these stones we never had known, that the stone is imported from France, and that it comes in wedge-shaped sections. These are put together by the miller, who also does the dressing. We came away carrying enough slow-ground corn meal to take care of our mush, corn bread, and scrapple needs for the winter.

The squirrels about the hotel, long a source of much entertainment, are fewer at this late season, but are busier than we have ever before seen them. Earlier in the year when they would come up to beg nuts, they would carry these a short distance away and make a shallow burial of them. At this season they are more insistent than ever, and once you give them a nut they do a real job of digging, being careful to thoroughly cover the burial site. Might want them this winter, you know.

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One of our sons, Doctor Jim, had just returned from a three and one-half year stretch in the Army Medical Corps, so we thought up the brilliant idea of taking him and his wife, Bette, to the convention. We anticipated the pleasure as well as the task of showing him around, getting him all set for future conventions. In less than thirty minutes after we had registered, he and his missus had disappeared, and for quite a long spell we saw no more of them. Not even the dancin' in the lobby, after dinner, had sufficed to keep them in the hotel; they just went sight-seeing, Mom said. Such is the way of youth!

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We are prepared to state that no other state organization has a corps of gals equal to ours, in ability to get things done, to know the answers, and to greet all comers with smiles that are contagious. No one, not having made at least a small survey of the matter, has any idea of how much work is done at headquarters. The incoming and outgoing letters alone would suffice to make it a big job, but this is but a minor part of it. For instance, the mere planning of the layout of THE JOURNAL is no small item, as evidenced when Miss Rokke showed the Editorial Board the forthcoming issue of THE JOURNAL, all pasted up, just as it will appear when it reaches your desk.

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Somehow, we always find something to say about George Daniels and his behavior at the conventions. Last year, you will recall, George, the official seconder to all motions, had a sleepy spell, slipping up on several occasions, and got peeved once when someone sneaked in on his preserves. This year, however, George took a few whiffs from his Benzedrine inhaler every few minutes, thus managing to be on the alert at all times. "I second the motion," or "I move that the nominations be closed and that the Secretary cast the unanimous ballot of the House" came from George, right at the proper moment. It has gotten so that when a motion is made the speaker automatically looks over toward George and gets the immediate response. Another thing about George, he never sits down in front, under the nose of the speaker; George is plenty smart, he knows that the speaker does not look down when presiding, but that his gaze is distributed all over the room, so George seats himself off to one side, about half-way back, and thus catches the eye of the speaker in no time.

We stopped in at Craig's, at Indianapolis, an old habit of ours, and there was Reba Stanley, fresh back from the convention, probably getting ready to fill her sweet-tooth with a bit of Craig's chocolates.

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Usually a sound sleeper, when in a comfortable bed such as we had, we were awakened during the night by a sonorous sound, starting in light tones but growing stronger as time went on. We laid there, trying to figure it out for quite some time, then began to investigate. Lord bless you, Mom was providing the entertainment. We had heard such sounds before, but never the heavy bass notes that prevailed on this occasion. After considerable cogitation we came to the conclusion that it must-a been due to the clean, fresh air coming in our three open windows, so fresh that it gave a different pitch to the usual notes.

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A chap walked up to us the first day of the convention and said, "For two years I have been looking for the wherewith to repay a loan you made to me just two years ago, when I sorely needed it," and he proffered me two good-looking cigars, stating that I had given him a cigar, a good one, at that time, and that he wanted to repay with interest. This was Walter U. Kennedy, of New Castle, and we recalled that we had seen him searching every pocket with a look of dismay. On inquiry we learned that he had no cigar, whence the loan. Told him we had just about abandoned the smoking habit, whereupon he transferred the two to his own pocket. Hope they kept him from the embarrassment of having to negotiate another loan later on in the session.

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There was just one drawback to the recent convention so far as the editor is concerned; he was unable to find a replacement for a very necessary part of his regular outfit. For years, probably more than sixty, we have been carrying a *Hoosier* buckeye in our left trouser pocket, this to ward off attacks of rheumatism—an old custom generally followed back in the Wild Cat days. These buckeyes will wear out in time, so have to be replaced. We have grown a bit careless, of late, in seeing to it that our hoard was replenished, and when about to leave for French Lick we discovered that the present model was just about gone. We, of course, thought we would be able to find plenty of them when down state, but not one was to be had. We went way back in the woods, at the rear of the hotel, but no buckeyes; we finally consulted a hotel attaché who had been on the job for many years, and he located a tree for us, but the buckeyes had disappeared. So, if any of our readers are interested in seeing to it that the aging editor manages to escape rheumatic symptoms, and knows the whereabouts of a modest supply of *Hoosier* buckeyes, we will be very glad to pay all shipping charges, plus a little bonus.

# Military News

Now a full commander, Dr. Paul K. Cullen, of Indianapolis, is stationed in the Pacific with Naval Base Hospital No. 18.

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We are informed that Lieutenant Loren F. Schmidt, of Indianapolis, is on Guam, having served there since last January.

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Formerly commanding officer of the 140th General Hospital in England, Colonel Morris C. Thomas, of Indianapolis, has reported to Camp Siebert, Alabama, for future assignment.

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Now assigned to the Walter Reed General Hospital, in Washington, D.C., Lieutenant Colonel Paul J. Fouts, of Indianapolis, is chief of the outpatient service.

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Serving as a flight surgeon, Dr. Joseph D. McDonald, of Evansville, has been promoted from major to lieutenant colonel. He is based on Guam with the 20th Air Force.

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Major Monroe K. Ruch, of Indianapolis, worked in various evacuation hospitals of the Third Army throughout the Normandy invasion, and is now on duty with the 35th Evacuation Hospital, in Germany.

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After twenty months overseas' duty with the 318th Station Hospital, in England, and the 191st Station Hospital, in Paris, Captain Frank H. Burton, of Indianapolis, has returned to this country. At both installations he was chief of anesthesia. The trip home was made in a C-54 in thirty-one hours.

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Captain Frederick R. Dettloff stopped in at THE JOURNAL office recently, and we learned that he is now in Cloverdale, having been retired from active duty in April, 1945. Doctor Dettloff served at Camp Atterbury and in Honolulu, where he was in the psychiatric division of the Tripler General Hospital.

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Captain Thomas W. Johnson, of Indianapolis, has been in Paris about five months, and is fortunate in being located in a beautiful hospital with a three-thousand-bed capacity. He is chief of the Otolaryngology Section. Before going to France, Captain Johnson was on duty two years in England.

H. H. Ash, M.D., of Lafayette, has recently been promoted from lieutenant commander to commander. He is stationed at the Great Lakes Naval Hospital.

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Major Howard A. Stellner, of Pendleton, is now in Tokyo. He is on duty as chief of the neuropsychiatric service with the 54th General Hospital.

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Dr. Earl P. Cripe, of Redkey, is now at Hamilton Field, California. He has been overseas with the air transport command.

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After receiving his discharge from the Army, Dr. Clifford C. Taylor has returned to Indianapolis, and is now connected with the x-ray department at St. Vincent's Hospital.

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After serving as flight surgeon with the 15th Air Force in Italy, Dr. Karl W. Vetter has resumed his practice in Elkhart. Dr. Vetter enlisted in June, 1942.

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Harold E. Ropp, M.D., recently returned to New Harmony to resume practice after spending twenty months overseas in the European Theatre as a flight surgeon with the rank of major.

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Announcement has been made that Dr. Francis E. Carrel, recently discharged from the service, has taken over the office and equipment of Dr. S. B. Sims, at Lafayette.

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Major Harold D. Pyle, of South Bend, is stationed at the Gardiner General Hospital, in Chicago, where he is in charge of the Medical Department.

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Dr. Edwin L. Libbert, of Lawrenceburg, who has been in the Army Medical Corps for more than four years, has recently been promoted to the rank of lieutenant colonel. Colonel Libbert is now in India with the 234th General Hospital, where he is chief of the x-ray department.

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After thirty-nine months of active service, Captain Orville A. Hall, of Muncie, has been honorably discharged from the Medical Corps, at Camp Atterbury. Doctor Hall first served at Fort Benning, Georgia; was stationed in the Antilles twenty-two months, serving in Porto Rico, Trinidad, and aboard a transport ship in the Atlantic. He plans to resume practice in Muncie.

Lieutenant Wendell E. Covalt, of Muncie, is stationed at the Naval Personnel Separation Center, at Shoemaker, California.

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Dr. F. T. Hallam, of Indianapolis, is now on terminal leave, and has resumed his civilian work. He carried the rank of colonel in the service.

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Dr. Meyer W. Kobrin, of Gary, has returned to practice there after his recent release from active duty with the United States Army.

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C. D. Mendenhall, M.D., has returned from service, and has opened an office in Indianapolis for general practice.

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Dr. Harold J. Halleck, of Winamac, has resumed his practice there, after recently returning from overseas' service with the Medical Corps.

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Major M. S. Brown, of Spencer, spent a short leave at home before reporting to San Antonio, Texas.

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Dr. E. H. Hall, of Dunkirk, has recently returned there after three and one-half years in the Army. Doctor Hall served with the rank of major.

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Sava M. Radivojevic, formerly of Valparaiso, has recently been released from the Army, and has gone to Louisville, Kentucky, for the practice of medicine.

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Dr. B. E. Sugarman has opened offices in French Lick after serving twenty-two months in the European Theatre of Operations. Dr. Sugarman formerly practiced in Williamstown, Kentucky.

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Dr. N. E. Keseric, formerly of Gary, has taken over the offices formerly occupied by Dr. George Dillinger, in French Lick. Major Keseric has recently been discharged from the Medical Corps of the Army.

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Captain Jay W. Thom returned to his home in Spencer after serving more than two and one-half years in the Pacific. At present he is stationed at Camp Campbell, Kentucky.

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Dr. Floyd T. Romberger, Jr., returned in August after two and one-half years in India and Burma, where he worked in the Surgeon's Office of the Advance Base Headquarters in northeastern India. This was during the time the Ledo Road (later renamed the Stilwell Road, when it was linked with the Burma Road) was being constructed. Dr. Romberger has now entered a residency in obstetrics at the William H. Coleman Hospital, in Indianapolis.

Dr. H. M. Pickard, of Elkhart, has been released from service, and has returned to Elkhart.

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Captain Fred O. Clark, of Syracuse, has informed THE JOURNAL office that he has been discharged from the Army, and has returned to Syracuse.

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Dr. George N. Love, of Connersville, has returned there after being released from the Army, and will soon resume practice. He carried the rank of captain.

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Carl J. Rudolph, M.D., was discharged from the Army on October twelfth, and has returned to civilian practice in South Bend. Doctor Rudolph recently received his lieutenant colonelcy.

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George W. Herrold, M.D., of Lafayette, was recently promoted to major. He has been stationed at Marseilles, France, with the Air Transport Command.

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We are pleased to announce that after three years as assistant command surgeon at Stout Field, Lieutenant Colonel Dudley A. Pfaff, of Indianapolis, has taken over the duties of command surgeon of the I Troop Carrier Command.

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On October eleventh, Dr. Paul L. Nelson, of Anderson, who was a captain in the Army Medical Corps, received his discharge at Camp Atterbury. He was in service for thirty-nine months, and spent twenty-one months in Burma and India.

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Following his recent discharge from the Army, Captain Herbert S. Dieckman, of Evansville, plans to take some postgraduate work, and will resume his medical practice in Evansville after the first of the year. Dr. Dieckman served overseas for three years, in England, Africa, Italy, Sicily, France, Germany, and Luxembourg.

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Dr. Richard H. Appel, of Indianapolis, is being discharged after many months in the Naval Medical Corps, where he served with the rank of commander. Doctor Appel's first assignment was at the Naval Training Station at Great Lakes, going on from there to New Zealand, New Caledonia, and the Hebrides. He then returned to Great Lakes, and was stationed there throughout the remainder of his service.

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Now serving as the chief of the neurology branch in the Office of the Surgeon General, in Washington, D. C., Major Alexander T. Ross, of Indianapolis, has been on temporary duty while making an inspection tour of the neuropsychiatric services at Billings and Wakeman General Hospitals. Major Ross expects to be released from service in the near future.

Having recently been transferred from a German prisoner-of-war hospital in northern Italy, Captain Don E. Kelly, of Indianapolis, is now with the 17th General Hospital in southern Italy. He is doing dermatology, and states that he is kept plenty busy.

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Lieutenant Colonel John E. Wyttenbach, of Indianapolis, is now commanding officer of the Sixth Field Hospital at Avonmouth, England. He was previously executive officer of the 173rd General Hospital at Nancy, France. The unit has now broken up into three separate groups and are servicing two American universities and the port.

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After a thirty-day leave spent in Indianapolis, Major Fred C. Reynolds is now chief of the orthopedic section of the Gardiner General Hospital, in Chicago. We have just learned of Major Reynolds' marriage to Miss Phyllis Terry, of Detroit, Michigan, which took place some time ago.

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A veteran of two overseas' tours in the Pacific area, Major William Donald Davidson, of Evansville, returned to Evansville November first, following his release from the Atterbury Separation Center. He served with the north sector hospitals in Hawaii in 1942, and returned to the West Coast early in 1943, where he served in hospitals in California, Oregon, and Washington until January, 1945. Since that time he had been serving with the 49th General Hospital in Manila. He expects to resume his practice in Evansville in the near future.

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Lieutenant Colonel Norman R. Booher, of Indianapolis, has returned to private practice, following five years' Army service. He was commanding officer at the Fort Benjamin Harrison Station Hospital, and following a course at the Command and General Staff School, at Fort Leavenworth, he was sent to the European theatre in 1943. He has seen service in England, France, Luxembourg, Belgium, Holland, and Germany. He was flown to New York from Europe, where he was commanding officer of the 56th General Hospital in Belgium.

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Major Fred N. Daugherty. of Crawfordsville, returned home on November fifth on terminal leave from Camp Atterbury. He is a veteran of World War I, and a former commander of the Byron Cox Post of the American Legion. He began his World War II service in February, 1942, and was sent overseas in March, 1943, after serving at Army medical stations in this country. His overseas' duty included North Africa, and Italy, where he was attached to the 105th Station Hospital of General Mark Clark's Fifth Army. He returned to the states last spring, where he was assigned to the station hospital of the Vigo Chemical Warfare Section. He expects to resume his practice in the near future.

On November first, Philip T. Holland, M.D., of Bloomington, was promoted to the rank of commander. Commander Holland is now stationed at the United States Naval Ammunition Depot at Crane, Indiana.

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In a letter from Major Lawrence W. Mueller, of Fort Wayne, he writes, "Today I again become a civilian. Needless to say, being a civilian will be a happy feeling." Major Mueller has been stationed at the LaGarde General Hospital, in New Orleans, and has been doing E.E.N.T. and endoscopic work for the surrounding area. He plans to open offices in Fort Wayne about the first of January.

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After having served as a flight surgeon in the Eighth Air Force for the past three years, Captain Loren H. Martin, of Indianapolis, received his discharge at Sioux Falls, South Dakota, and has returned to practice here. Captain Martin served eighteen months overseas in the European Theatre of Operations. He saw service in England, France, Belgium and Denmark. He has seven battle stars and has been awarded the Presidential Citation.

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On duty with the 42nd General Hospital, which went to Yokohama with General MacArthur's occupation forces, Captain John J. Flick, of Indianapolis, was one of the nineteen medical officers recently chosen to go to Hiroshima to study the effects of the atomic bomb on the survivors. Captain Flick has been in military service since August, 1943, and has served at various places in the United States and the Philippines.

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After almost five years of service, Dr. Harry M. Covell, of Auburn, is resting at his home there, following his discharge from the Army Medical Corps. He was stationed at Fort McClellan, Alabama; Camp McQuaide, California; Camp Adair and Camp White, both in Oregon, and then went to the Philippines during the invasion of Leyte, and later was in the invasion of Okinawa. His last service was in Japan. He entered the service as a captain, later became a major, and then lieutenant colonel.

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The first Elkhart physician to enter the Army during the emergency created by World War II, Major Irving Mishkin has returned, on terminal leave, and will resume his practice there. For nineteen months he was chief of Medical Service at station hospitals at Fort Benjamin Harrison, Indiana, and in California; then served for eighteen months as medical unit commander at Camp Stoneman, California; was radiologist for sixteen months in the Toledo, Ohio, reception center; and then was assigned to an Army hospital ship which was attached to the Seventh Army for twelve months. He wears the American Defense, Mediterranean and ETO ribbons, and stars for the Rome-Arno, Southern France, and Po Valley campaigns.

After three years and seven months' service as a medical officer in the Navy, during which time he won seven battle stars, Dr. Arthur P. Rhamy has returned to Wabash to resume his practice. Doctor Rhamy served overseas twenty-one months, during which time he participated in the invasion of Bougainville, Tarawa, Hollandia, New Guinea, and Okinawa, as well as others. He was with the task force which made the first raid on Truk and the first raid on the Marianas. Doctor Rhamy held the rank of commander.

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Lieutenant (j.g.) Joseph R. Eastman, Jr., who was a resident in surgery at the City Hospital when he entered the Navy in July, 1944, recently spent a two-week leave with his family, in Indianapolis. He has been with the Fleet Marine Force, and the boys were flying dive bombers, which are, of course, the Douglas Dauntless, but which became so battered that they referred to them as the "Douglas doubtful." He was proud of his group, saying, "We had the best baseball team in the Philippine Islands." Lieutenant Eastman is not getting out of service yet—"not enough points," he said, and has been assigned to the *U.S.S. Iowa.*

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Dr. John F. Parker, of Indianapolis, has returned to private practice after more than three years in the Army. The last twenty months were spent in the European Theatre, where Dr. Parker was on duty as chief of the surgical service of the 45th Field Hospital. On D-Day Dr. Parker performed operations on boats in the English Channel, and two days later he helped set up the first field hospital on the Normandy beachhead. With the First Army he served in France, Luxembourg, and Belgium; was in the Battle of the Bulge at Bastogne, and crossed the Remagen Bridge to Leipzig and Nürnberg. After victory in Europe he went to Czechoslovakia with Patton's Third Army.

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Dr. Ezra R. Haslem, of Terre Haute, has resumed his practice there, after his recent separation from the service. Dr. Haslem entered the Army July 5, 1942, at Fort Knox, Kentucky. He was transferred to Camp Breckenridge, to the surgical staff, for eighteen months. From there he was sent to the University of Pennsylvania and the Walter Reed Hospital, Washington, D. C., for four months' training. In January, 1944, he went to Billings General Hospital, and then was appointed depot surgeon at A.S.F. Depot, Columbus, Ohio. In November, 1944, Captain Haslem helped organize the 85th Field Hospital, consisting of three units, of which he was chief of surgery. This hospital went overseas, and was stationed at Adderbury, England; then at LeHavre, France; then Hastiere, Belgium; then to Aachen and Elsdorf, Germany, near Cologne and Bohn. At Cutzschen, Germany, they took over a German Catholic Hospital, which was turned over to the 65th Field Hospital at the end of the war.

Major Eugene Austin, of Anderson, arrived home on October nineteenth, after three years' service in the South Pacific with the Fifth Air Force, which participated in ten combat areas—New Guinea, Guadalcanal, Western Pacific, Northern Solomons, Southern Philippines, Luzon, and the air offensives in Japan, Ryukyu, China Coast, and the Bismarck Archipelago. He will return to the University of Michigan to complete his residency in Pediatrics after his terminal leave. At home he met, for the first time in fifteen years, his brother, Lieutenant Commander John Austin, who was en route to the South Pacific after three years in Washington, in the photographic section of the Naval Bureau of Aeronautics.

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Major Walter C. Anderson, of Terre Haute, has returned to resume his practice, after more than three years' service. Major Anderson was commissioned captain on June 12, 1942, and reported for duty as assistant chief of surgery at Sacramento, California, later becoming chief of surgery at Stockton Field, then was transferred to Deming Field, Deming, New Mexico. He was promoted to major in September, 1943, and shortly thereafter was transferred as chief of surgery to the AAF Regional Hospital, Roswell, New Mexico, where he served until August, 1944, when he was transferred to the Marfa Army Air Field, at Marfa, Texas, where he became post surgeon and chief of the surgical service at the Marfa Hospital.

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Colonel Will W. Holmes, of Logansport, who has been in the Army Reserve Corps since 1917, was retired the twelfth of June and is practicing again in Logansport. Colonel Holmes was stationed at Camp Croft, South Carolina, as chief of the E.E.N.T. Service when he was given a few hours' notice that he was being transferred to China, for duty as an instructor with the Chinese Army. The Chinese Army at that time had no medical department, and Colonel Holmes was one of the six colonels sent to China to establish the Medical Department there. The first thing they did was to create a small school similar to the United States Army's Carlisle Barracks. In the classes there fifteen per cent could neither read nor write in any language, and in one class of 460 only four were graduate physicians. Colonel Holmes stated that the eagerness of the people of China to learn was pitiful. He said these men would walk from four to six hundred miles, carrying their one pair of shoes (for when they were gone there were no others) in order to attend this school. The school taught field evacuation and field dressings. Everything was pack-carry; there were no ambulances, and the litters were made of bamboo poles with grain sacks instead of canvas. Colonel Holmes also flew over the Hump into Burma several times, and spent some time in a leprosorium in India, which had 940 in-patients and 1800 out-patients.

# Deaths

## DIED IN MILITARY SERVICE

Major Gordon H. Haggard, M.C., Army of the United States, has been declared by the War Department as having been killed in action. Major Haggard was listed as missing on October 7, 1944, when the B-17 of which he was a crew member was lost on a bombing mission to Politz, Germany.

There is no definite evidence of Major Haggard's death; however, a year has passed since his plane received a direct hit from enemy anti-aircraft and exploded in air above Stettin Bay, and according to War Department procedure he is listed as having died on the date the plane went down. Four crew members were blown out of the plane by the explosion and were rescued from the water. In letters to Mrs. Haggard these members stated that none of those aboard had a chance to bail out of the plane.

*Major Gordon H. Haggard*

Major Haggard entered the Army on March 27, 1941, holding a lieutenancy in the Reserve Corps. He was promoted to captain in 1941, and to major in 1943. Major Haggard's first station was Fort Oglethorpe, Georgia. While on duty as division surgeon with the 76th Division, at Fort Meade, Maryland, Major Haggard made models of war wounds, which were used in the production of bandages and were adopted by the Army as a standard item of issue. The original models are in the American War College Museum in Washington, D. C. They have proved very valuable in training medical troops to give aid on the battlefield, and Major Haggard was awarded the Legion of Merit for their invention and construction.

In 1942 Major Haggard entered the Air Corps. He took his flight surgeon's training at Randolph Field, Texas, and from there was sent to various classification centers, finally being sent to an air base in Ephrata, Washington, as group surgeon. There he established a two-hundred-bed hospital, and while there became greatly interested in high-altitude flying work, in regard to training crews for flying. Major Haggard went overseas from Grand Island, Nebraska, with this group in January, 1944. He made it a practice to go on at least one mission a month so that his men would have confidence in him, and it was this conscientiousness that cost him his life. His commanding officer commended his work on psychoneurosis and combat fatigue, and wrote: "Combat personnel listened and leaned on him because they knew he knew from experience. He saved many, not only from death but from the living death by his extreme devotion to duty without regard for his own personal safety."

In addition to the Legion of Merit, Major Haggard was awarded the Air Medal with Oak Leaf Clusters, the Presidential Unit Citation, and had two battle stars on his European Theatre ribbon.

Major Haggard was thirty-six years of age. He graduated from the Indiana University School of Medicine in 1933, and had practiced since that time in Hope. He was a member of the Bartholomew County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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**George G. Richardson, M.D.**, retired physician of Marion, died November eighth at the family home, after an illness of two years. He was a graduate of the Medical College of Indiana, Indianapolis, in 1905.

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**O. H. Swantusch, M.D.**, of Angola, died at his home October thirteenth, at the age of sixty-one. He was a graduate of the Fort Wayne College of Medicine, in 1905. During World War I he was attached to the Medical Corps at Fort Benjamin Harrison. He was a member of the Steuben County Medical Society, the Indiana State Medical Association, and the American Medical Association.

**Jerome De Motte, M.D.**, of Odon, died November fifth, at the age of seventy-six. He was a graduate of the Medical College of Ohio, Cincinnati, and was a member of the Daviess-Martin County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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**C. W. Brown, M.D.**, of Rolling Prairie, died suddenly at his home, November first. He was forty-eight years of age. He graduated from the Indiana University School of Medicine in 1931. He was a member of the LaPorte County Medical Society, the Indiana State Medical Association, and a Fellow of the American Medical Association.

**Arthur H. Northrup, M.D.**, formerly of Markle, died November fourth at Clearwater, Florida, where he had lived for the past two years. He was seventy years of age, and had been in failing health for some time. He was a graduate of the Medical College of Indiana, Indianapolis, in 1904, had been a county health officer and was a member of the Huntington County Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

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**Oscar H. Stewart, M.D.**, of Orleans, died on October nineteenth, at the age of eighty-five years. He graduated from the Pulte Medical College, in Cincinnati, in 1885. Prior to his retirement six years ago, because of ill health, he had practiced medicine for more than half a century. He was a member of the Orange County Medical Society, an honorary member of the Indiana State Medical Association, and a member of the American Medical Association.

**B. C. Dale, M.D.**, of Marion, died at his home October twenty-sixth, at the age of seventy-four. He was a graduate of the Medical College of Indiana, Indianapolis. At the time of his death he was county coroner and had also served as public health officer. He was a member and past president of the Grant County Medical Society, and a member of the Indiana State Medical Association and the American Medical Association.

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**Oliver V. Schuman, M.D.**, of Columbia City, died October twenty-third, at his residence, at the age of eighty-two years. He was a graduate of Northwestern University Medical School, Chicago, in 1889. During World War I, Dr. Schuman served as Medical Defense officer and chairman of the Advisory Board to the Conscription Board. He was a member of the Whitley County Medical Society, an honorary member of the Indiana State Medical Association, and a member of the American Medical Association.

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# News Notes

Since October first, Dr. Martha Moore has been on the staff of the Madison State Hospital. She was formerly at the Muscatatuck State School.

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Dr. Elmer R. Maierhofer, formerly of Walkerton, has closed his office and has gone to Chicago for some postgraduate work, after which he plans to open a new office in Ottawa, Illinois.

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The Indiana Medical College Alumni Class of 1907 held a luncheon meeting at French Lick on November seventh, during the convention, with Dr. William O. McKittrick, vice-president, of Washington, Indiana, presiding. No business session was held.

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Dr. R. E. Baker, of Orleans, who is eighty-four years old, is still up-and-doing, working far beyond regular hours with little time for rest. He recently even found time to supply our office with some news items. Indiana medicine owes its success to pioneer physicians such as Doctor Baker.

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It has been announced that Dr. Ralph H. Nestmann, of Indianapolis, who recently returned from eighteen months of overseas' duty, has been appointed as a member of the medical staff of the Marion County Tuberculosis Hospital. Doctor Nestmann served overseas in the Medical Corps of the 36th Division, on duty as a battalion surgeon.

At a recent meeting of the Executive Board of the American Roentgen Ray Society, at the Palmer House in Chicago, Dr. R. C. Beeler, of Indianapolis, was named president-elect of the society.

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Announcement has been made that the Annual Clinical Conference of the Chicago Medical Society will be held March 5, 6, 7 and 8, 1946, at the Palmer House. Make your hotel reservations now to attend this instructive meeting.

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Dr. R. N. Washburn, of Rensselaer, has been appointed coroner of Jasper County, to fill the unexpired term of Dr. M. D. Gwin, who has moved to Florida.

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Sponsored by the Jefferson County Medical Society, with the cooperation of the county nurse, the P.T.A. and school officials, an anti-contagion program was instituted in Jefferson County on November twelfth, with 1,630 immunizations against smallpox, diphtheria, tetanus, and whooping cough.

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The office formerly occupied by Dr. W. S. Coleman, of Rushville, who is retiring from practice, has been taken over by Dr. Robert B. Johnson, recently discharged from the Army Medical Corps. Doctor Johnson served four and one-half years in the armed forces, fourteen months of which was overseas, and a year of which was with the 155th General Hospital in England. He had charge of a prisoner-of-war hospital center near Frankfurt, Germany.

# Membership Roster

## INDIANA STATE MEDICAL ASSOCIATION—1945

Following is a list of the members of the Indiana State Medical Association, including the names of all those who were members on November 30, 1945. Membership established after that date could not be included in this issue of THE JOURNAL. Members are listed in the county in which they hold their membership.

An asterisk (*) precedes the names of physicians who are in the armed forces.

Military addresses, for obvious reasons, are not published in this list. If the addresses of your friends appearing in the list below are not known to you, call the Indiana State Medical Association, FRanklin 3627, and if the addresses are known here they will be given to you.

The letter (H) following a name indicates that the physician is an honorary member of his local society and of the Indiana State Medical Association.

Names of members who have died during the year do not appear in this list.

If any errors are found in this list, please report them to THE JOURNAL, 1017 Hume Mansur Building Indianapolis 4, Indiana. The cooperation of members is urgently requested.

| Name | City | County |
|---|---|---|
| *Aagesen, W. J. | Anderson | Madison |
| Abel, J. A. | South Bend | St. Joseph |
| Abel, Virgil | Vallonia | Jackson |
| *Abell, Charles F. | Marion | Grant |
| Acker, Robert B. | South Bend | St. Joseph |
| Acre, R. R. | Evansville | Vanderburgh |
| Adair, Wm. K. | Crothersville | Jackson |
| Adams, C. J. | Kokomo | Howard |
| Adams, D. S. | Indianapolis | Marion |
| Adams, J. R. | Fort Wayne | Allen |
| Adams, Julia L. | Muncie | Delaware-Blackford |
| Adams, Max R. | Flora | Carroll |
| Adams, William B. | Muncie | Delaware-Blackford |
| Adamski, Michael S. | Logansport | Cass |
| Ade, C. H. | La Fayette | Tippecanoe |
| Ade, Mary | La Fayette | Tippecanoe |
| *Adkins, H. C. | Indianapolis | Marion |
| Adkins, Onan C. | Indianapolis | Marion |
| Adler, Raymond N. | Evansville | Vanderburgh |
| Aiken, Milo M. | Plainfield | Hendricks |
| *Ake, Loren | Cambridge City | Wayne-Union |
| Aker, Charles L. | Greencastle | Putnam |
| Albertson, F. P. | Indianapolis | Johnson |
| Alburger, Henry R. | Indianapolis | Marion |
| Aldrich, Harry | Fort Wayne | Allen |
| *Aldrich, Harry | Indianapolis | Marion |
| Aldrich, Howard | Indianapolis | Marion |
| Alexander, H. H. | Princeton | Gibson |
| *Alexander, J. E. | Evansville | Vanderburgh |
| *Alexander, J. M. | Argos | Marshall |
| Alexander, O. O. | Terre Haute | Vigo |
| Alexander, P. M. | Martinsville | Morgan |
| Alexander, W. P. (H) | Gary | Lake |
| *Allen, Fred K. | Fredericksburg | Washington |
| Allen, Hubert E. | Richmond | Wayne-Union |
| Allen, J. L. | Greenfield | Hancock |
| *Allen, Lionel H. | Bedford | Lawrence |
| Allen, Orris T. | Terre Haute | Vigo |
| Allenbaugh, A. E. | Evansville | Vanderburgh |
| Almquist, C. O. | Gary | Lake |
| Altier, W. H. | Fowler | Benton |
| Alvis, Edmond O. | Indianapolis | Marion |
| *Alward, John Haney | Sioux Falls, S.D. | Marion |
| *Ambrose, J. C. | Noblesville | Hamilton |
| Ames, George (H.) | Eaton | Delaware-Blackford |
| Amick, Charles L. | Wakarusa | Elkhart |
| *Amos, R. L. | New Castle | Henry |
| Amy, W. E. | Corydon | Harrison |
| *Anderson, Charles P. | Gary | Lake |
| Anderson, D. W. | Evansville | Vanderburgh |
| Anderson, R. J. | Indianapolis | Marion |
| Anderson, R. M. | Vincennes | Knox |
| *Anderson, Walter C. | Terre Haute | Vigo |
| *Anderson, W. C. | Rockville | Parke-Vermillion |
| *Andrews, C. L. | Greenfield | Hancock |
| Andrews, D. Lee | Louisville, Ky. | Marion |
| Annis, Homer B. | Bluffton | Wells |
| Anthoulis, George D. | Gary | Lake |
| *Appel, R. H. | Indianapolis | Marion |
| Applegate, A. Earl | La Fayette | Tippecanoe |
| Applegate, F. M | Corydon | Harrison |
| *Arbogast, John L. | La Fayette | Tippecanoe |
| Arbogast, Paul B. | Vincennes | Knox |
| *Arbuckle, Russell | Indianapolis | Marion |
| Arbuckle, Wm. E. | Indianapolis | Marion |
| Arford, R. D. | Middletown | Henry |
| Arisman, R. K. | South Bend | St. Joseph |
| *Arlook, Theodore D. | Elkhart | Elkhart |
| Armington, C. L. | Anderson | Madison |
| Armington, John C. | Anderson | Madison |
| Armington, Robert | Anderson | Madison |
| Armstrong, T. D. | Michigan City | La Porte |
| Arnett, A. C. | La Fayette | Tippecanoe |
| *Arnold, Aaron L. | Indianapolis | Marion |
| *Arnold, Ralph D. | Ligonier | Noble |
| Arnold, Ralph N. | Greenfield | Hancock |
| *Aronson, Sidney S. | Indianapolis | Marion |
| Arthur, H. M. | Hazelton | Gibson |
| Arthur, N. Maude | Washington | Daviess-Martin |
| Asbury, W. D. | Terre Haute | Vigo |
| *Ash, H. H. | West Lafayette | Tippecanoe |
| Asher, E. O. | New Augusta | Marion |
| Asher, James W. | New Augusta | Marion |
| Ashworth, L. N. | Connersville | Fayette-Franklin |
| *Atcheson, Bellfield | Gary | Lake |
| Atchison, K. C. | Rockport | Spencer |
| Atkins, C. C. | Rushville | Rush |
| Atkinson, C. W. | Boswell | Benton |
| Aucreman, C. J. | Montpelier | Delaware-Blackford |
| Austin, Eugene W. | Anderson | Madison |
| Austin, F. H. (H) | Bloomington | Monroe |
| Austin, M. A. | Anderson | Madison |
| Austin, R. P. | Bedford | Lawrence |
| Ayres, Kenneth D. | Anderson | Madison |
| *Ayres, W. W. | Hartford City | Delaware-Blackford |
| *Babb, Forrest, Jr. | Muncie | Delaware |
| Bachrach, Moritz | South Bend | St. Joseph |
| Backer, Henry G. | Ferdinand | Dubois |
| Badders, A. C. | Portland | Jay |
| *Baganz, C. N. | Uniondale | Wells |
| Bahr, Max A. | Indianapolis | Marion |
| Bailey, Edwin B. | Linton | Greene |
| *Bailey, E. W. | Logansport | Cass |
| *Bailey, L. S. | Zionsville | Boone |
| Bailey, Paul P. | Fort Wayne | Allen |
| *Bailey, Perry W. | Fort Wayne | Allen |
| Bailey, W. A. | Vincennes | Knox |
| Baitinger, H. M. | Gary | Lake |
| Bakemeier, O. H. | Indianapolis | Marion |
| Baker, A. M. | New Albany | Floyd |
| Baker, C. S. | Evansville | Vanderburgh |
| Baker, G. D. | Crandall | Harrison |
| Baker, Herman | Evansville | Vanderburgh |
| Baker, J. S. | Evansville | Vanderburgh |
| Baker, J. V. | Edinburg | Johnson |
| *Baker, Leslie M. | Muncie | Delaware-Blackford |
| Baker, Milan D. | Culver | Marshall |
| Baker, Robert E. (H) | Orleans | Orange |
| Baker, Warren | Westville | LaPorte |
| Baker, W. H. | South Bend | St. Joseph |
| Bakes, Fred C. | Vevay | Switzerland |
| Balch, James F. | Indianapolis | Marion |
| Baldridge, E. R. | Terre Haute | Vigo |
| *Baldridge, W. O. | Terre Haute | Vigo |
| Baldwin, John H. | Jeffersonville | Clark |
| Ball, Clay A. | Muncie | Delaware-Blackford |
| Ball, Thomas Z. (H) | Crawfordsville | Montgomery |
| Balla, Morris | South Bend | St. Joseph |
| Ballard, C. A. | Logansport | Cass |
| Ballard, Robert J. | Lebanon | Boone |
| Ballenger, W. E. | Richmond | Wayne-Union |
| *Balsbaugh, George | N. Manchester | Wabash |
| Barden, Frank W. | Oakland City | Gibson |
| *Baltes, Joseph H. | Fort Wayne | Allen |
| Banister, R. F. | Indianapolis | Marion |
| Bankoff, Milton L. | Michigan City | LaPorte |
| *Banks, H. M. | Indianapolis | Marion |
| Barclay, I. C. | Evansville | Vanderburgh |
| *Bard, Frank B. | Crothersville | Jackson |
| Barnes, Helen B. | Greenwood | Marion |
| Barnett, R. E. | Peru | Miami |
| *Barnett, Wm. | Logansport | Cass |
| Barnum, Emerson | Shelbyville | Shelby |
| *Barron, E. A. | La Porte | La Porte |
| Barrow, John H. | Dale | Spencer |
| Barry, M. J. | Indianapolis | Marion |
| *Bartle, J. Leo | Knightstown | Henry |
| Bartley, Max D. | Indianapolis | Marion |
| Bartholomew, A. C. | Fort Wayne | Allen |
| Bartholomew, Mary | Goshen | Elkhart |
| Barton, W. M. | Centerville | Wayne-Union |
| Bascomb, Marshall R. | Calumet City, Ill. | Lake |
| *Baskett, R. J. | Jonesboro | Grant |
| Bass, F. E. | Shelbyville | Shelby |
| Bassett, Clancy | Thorntown | Boone |
| Bassler, C. R. | Mishawaka | St. Joseph |
| Bassett, Margaret | Bloomington | Monroe |
| Batman, F. H. | Bloomington | Monroe |

| Name | City | County |
|---|---|---|
| Batman, Gordon W. | Indianapolis | Marion |
| Bauer, A. J. | La Fayette | Tippecanoe |
| Bauer, Thomas B. | Indianapolis | Marion |
| *Baumgart, E. T. | Indianapolis | Marion |
| Baumgartner, Jeraldine | Fort Wayne | Allen |
| *Baumrucker, George O. | Indianapolis | Marion |
| *Baxter, J. W., Jr. | New Albany | Floyd |
| *Baxter, Neal | Bloomington | Monroe |
| *Baxter, Samuel M. | New Albany | Floyd |
| Bayley, R. H. | La Fayette | Tippecanoe |
| Beach, Robert R. | Indianapolis | Marion |
| *Beamer, G. D. | Delphi | Carroll |
| Beams, Ralph H. | Fairmount | Grant |
| Bear, L. H. (H) | Vevay | Switzerland |
| Beard, Paul H. | Indianapolis | Marion |
| Beardsley, Frank A. | Frankfort | Clinton |
| Beasley, T. J. | Indianapolis | Marion |
| Beatty, Norman M. | Indianapolis | Marion |
| *Beaver, Ernest R. | Indianapolis | Marion |
| *Bechtold, S. E. | South Bend | St. Joseph |
| Beck, Evart M. | Indianapolis | Marion |
| Beck, H. A. | Lebanon | Boone |
| Becker, Phillip H. | Crown Point | Lake |
| Beckes, Ellsworth | Vincennes | Knox |
| Beckman, H. F. | Indianapolis | Marion |
| Bedwell, Marion H. | Sullivan | Sullivan |
| Beeler, Bruce H. | Evansville | Vanderburgh |
| Beeler, Raymond C. | Indianapolis | Marion |
| *Beetem, L. F. | Madison | Jefferson |
| Beggs, L. F. | Columbus | Bartholomew |
| Behn, Walter M. | Gary | Lake |
| *Beierlein, Karl | Fort Wayne | Allen |
| Belden, L. D. | Indianapolis | Marion |
| Bell, D. W. | Otwell | Pike |
| Bender, Cecil K. | Goshen | Elkhart |
| Bendler, Carl H. | Gary | Lake |
| Benham, James W. (H) | Columbus | Bartholomew |
| *Bennett, J. B. | Warren | Huntington |
| Benninghoff, D. R. | Fort Wayne | Allen |
| Benz, Jesse | Marengo | Crawford |
| *Benz, O. F. | Whiting | Lake |
| Beresford, G. B. (H) | Owensville | Gibson |
| Berger, Henry I. | Indianapolis | Marion |
| Berghoff, Raymond | Fort Wayne | Allen |
| *Berke, Robert | South Bend | St. Joseph |
| Berkebile, J. B. | Peru | Miami |
| Berman, Jacob K. | Indianapolis | Marion |
| Bernheimer, H. L. (H) | Terre Haute | Vigo |
| Bernoske, D. G. | Michigan City | La Porte |
| Berns, P. C. | Linton | Greene |
| *Bernstein, Joseph | Indianapolis | Marion |
| Bethea, Dennis A. | Hammond | Lake |
| Beverland, M. E. | Indianapolis | Marion |
| Bibler, Henry E. | Muncie | Delaware-Blackford |
| *Bibler, L. D. | Indianapolis | Marion |
| Bickel, David A. | South Bend | St. Joseph |
| Bickel, J. E. | Fort Wayne | Allen |
| Bicknell, G. F. | East Chicago | Lake |
| Bierly, Fred | Elizabeth | Floyd |
| Bigelow, O. P. | Roanoke | Huntington |
| Bigham, J. C. | Batesville | Ripley |
| *Bigsby, Frank L., Jr. | Evansville | Vanderburgh |
| *Bill, Robert O. | Indianapolis | Marion |
| Billman, Gustus S. | Shelbyville | Shelby |
| Bills, L. F. | Gary | Lake |
| Bills, R. N. | Gary | Lake |
| Bird, Charles R. | Indianapolis | Marion |
| Birdzell, John P. | Crown Point | Lake |
| Birmingham, P. J. | South Bend | St. Joseph |
| Bishop, Charles A. | South Bend | St. Joseph |
| Bitler, C. C. | New Castle | Henry |
| *Bixler, L. C. | South Bend | St. Joseph |
| Black, Claude S. | Warren | Huntington |
| Black, Edgar K. | Wabash | Wabash |
| *Blackburn, Erwin | South Bend | St. Joseph |
| Blackford, Florence | Indianapolis | Marion |
| Blackford, Ralph E. | Rochester, Minn. | Marion |
| Blackford, Roger W. | Indianapolis | Marion |
| Blaize, J. L. | New Castle | Knox |
| Bland, Curtis | (Long Beach, Calif.) | Vigo |
| Bland, H. E. | Fairbanks | Sullivan |
| *Blatt, A. E. | Indianapolis | Marion |
| Blazey, A. G. | Washington | Daviess-Martin |
| *Bledsoe, James G. | New Castle | Henry |
| *Blemker, Russell | Greensburg | Decatur |
| Blessinger, Paul J. | Jasper | Dubois |
| Blinks, E. G. | Michigan City | Lake |
| Bloemker, E. F. | Indianapolis | Marion |
| Blood, R. P. | Hebron | Porter |
| Bloom, Asa Ward | Marion | Grant |
| Bloomer, J. R. | Rockville | Parke-Vermillion |
| Bloomer, R. S. | Rockville | Parke-Vermillion |
| Blosser, B. A. | Fremont | Steuben |
| Blosser, H. V. | Fort Wayne | Allen |
| Blossom, Paul W. | Richmond | Wayne-Union |
| Blum, Leon L. | Terre Haute | Vigo |
| Boardman, Carl | Gary | Lake |
| Boaz, John J. | Indianapolis | Marion |
| *Boerger, Victor L. | Fort Wayne | Allen |
| Bogardus, C. R. | Austin | Scott |
| Boggs, E. F. | Indianapolis | Marion |
| Bohner, C. B. | Indianapolis | Marion |
| Bolin, John T. | Hammond | Lake |
| *Bolin, Robert S. | Goshen | Elkhart |
| *Boling, R. L. | Indianapolis | Marion |
| Bolka, B. J. | South Bend | St. Joseph |
| Bond, Charles S. (H) | Richmond | Wayne-Union |
| Bond, George S. | Indianapolis | Marion |
| Bond, Walter | Clay City | Clay |
| Boner, G. W. | Butlerville | Jennings |
| Bonifield, H. F. | Warren | Huntington |
| Booher, Irvin E. | Connersville | Fayette-Franklin |
| Booher, Norman R. | Indianapolis | Marion |
| Booher, Olga | Indianapolis | Marion |
| Boone, John C. (H) | South Bend | St. Joseph |
| Bopp, D. W. | Whiting | Lake |
| Bopp, Henry W. | Terre Haute | Vigo |
| Borders, Theo. R. | Fort Wayne | Allen |
| Boren, Paul | Poseyville | Posey |
| Boren, Samuel W. (H) | Poseyville | Posey |
| Borland, R. M. | Bloomington | Monroe |
| Bosenbury, C. S. | South Bend | St. Joseph |
| Bosselmann, Clarence C | Fort Wayne | Allen |
| Bostwick, James G. | Mishawaka | St. Joseph |
| Boswell, Robert W. | Hammond | Lake |
| Bothwell, C. G. | Martinsville | Morgan |
| Bottorff, David C. | Charlestown | Clark |
| Boulware, J. P. | Bloomington | Monroe |
| Bounell, E. G. | Hillsboro | Fountain-Warren |
| Bounell, Harry M. (H) | Waynetown | Montgomery |
| Bowdoin, G. E. | Elkhart | Elkhart |
| Bowers, Copeland C. | Kokomo | Howard |
| Bowers, Don D. | Indianapolis | Marion |
| Bowers, G. T. | Fort Wayne | Allen |
| Bowers, John A. | Kokomo | Howard |
| *Bowers, J. W. | Fort Wayne | Allen |
| Bowles, J. H. | Muncie | Delaware-Blackford |
| *Bowman, Charles M. | Albion | Noble |
| Bowman, George W. | Indianapolis | Marion |
| Bowman, I. E. | Odon | Daviess-Martin |
| Boyd, C. L. | Vincennes | Knox |
| Boyd, Charles S. | East Chicago | Lake |
| Boyd, Clarence E. | West Baden | Orange |
| Boyd, David A., Jr. | Indianapolis | Marion |
| *Boyd, Nelson E. | Freelandville | Knox |
| Boyd, Stella N. | Evansville | Vanderburgh |
| Boyd-Snee, Harry (H) | South Bend | St. Joseph |
| *Boyer, E. B. | Indianapolis | Marion |
| Boyer, Floyd A. | Indianapolis | Marion |
| Boyer, Grace M. | Marion | Grant |
| Boys, Floyd E. | Indianapolis | Marion |
| Boys, F. F. | East Chicago | Lake |
| Bradfield, John C. | Logansport | Cass |
| Bradley, Stephen C. | Terre Haute | Vigo |
| Brady, Samuel | Gary | Lake |
| Braginton, Fred (H) | Hammond | Marion |
| Brandman, Harry | Whiting | Lake |
| Brauchla, C. H. | Anderson | Madison |
| Brauer, A. A. | East Chicago | Lake |
| Braun, Benjamin D. | East Chicago | Lake |
| Braunlin, Robert F. | Marion | Grant |
| Braunlin, W. H. | Marion | Grant |
| Braunsdorf, R. L. | South Bend | St. Joseph |
| Brayton, John R. | Indianapolis | Marion |
| Brayton, Lee | Indianapolis | Marion |
| Brazelton, O. T. | Princeton | Gibson |
| Brendel, O. E. | Zionsville | Boone |
| *Brenner, Andrew M. | Winchester | Randolph |
| Brenner, L. E. | Winchester | Randolph |
| Bretz, W. D. | Huntingburg | Dubois |
| Brickley, H. D. | Bluffton | Wells |
| *Bridwell, Edgar | Delphi | Carroll |
| Briggs, Carl F. | Sullivan | Sullivan |
| Briggs, J. H. | Churubusco | Whitley |
| Brink, C. C. | Gary | Lake |
| Briscoe, C. E. | New Albany | Floyd |
| *Britton, W. D. | Indianapolis | Marion |
| Brock, Earl E. | Anderson | Madison |
| Brodie, Donald W. | Indianapolis | Marion |
| *Brody, Arthur | East Chicago | Lake |
| Bronson, Paul J. | Terre Haute | Vigo |
| Brookie, Roger W. | Flora | Carroll |
| Brooks, H. L. | Michigan City | La Porte |
| Broomes, Edward L. C. | East Chicago | Lake |
| Brosius, Robert H. W. | Fort Wayne | Allen |
| *Brother, Geo. M. | Indianapolis | Marion |
| *Brown, A. E. | Indianapolis | Marion |
| *Brown, D. B. | Gary | Lake |
| Brown, David E. | Indianapolis | Marion |
| Brown, Edward A. | Indianapolis | Marion |
| Brown, Frances T. | Indianapolis | Marion |
| *Brown, James C. | Valparaiso | Porter |
| Brown, J. S. | Carlisle | Sullivan |
| Brown, Karl T. | Muncie | Delaware-Blackford |
| *Brown, K. H. | New Albany | Floyd |
| *Brown, M. S. | Spencer | Owen |
| Brown, R. E. | Cayuga | Parke-Vermillion |
| Brown, Robert R. | Terre Haute | Vigo |
| Brown, Robert | Marion | Grant |
| Brown, Stanley L. | Hammond | Lake |
| *Brown, Wendell E. | Indianapolis | Marion |
| *Browning, J. S. | Indianapolis | Marion |
| *Browning, W. M. | Indianapolis | Marion |
| Brubaker, E. H. (H) | Indianapolis | Marion |
| Brubaker, Harold S. | Huntington | Huntington |
| Brubaker, O. G. | N. Manchester | Wabash |
| *Bruegge, T. J. | Kokomo | Howard |
| Bruetsch, Walter L. | Indianapolis | Marion |
| Bruggeman, H. O. | Fort Wayne | Allen |
| Bruner, C. H. | Greenfield | Hancock |
| Bruner, Ralph | Jeffersonville | Clark |
| *Bryan, F. A. | Indianapolis | Marion |
| Bryan, Kathryn M. | Logansport | Cass |
| Bryan, S. L. | Evansville | Vanderburgh |
| *Buchanan, W. D. | Bremen | St. Joseph |
| Buche, F. P. | Richmond | Wayne-Union |
| Buckley, E. P. | Jeffersonville | Clark |
| Buckner, Doster | Fort Wayne | Allen |
| Buckner, Joy F. | Bluffton | Wabash |
| *Buechner, F. W. | South Bend | St. Joseph |
| Buehl, Robert F. | Indianapolis | Marion |
| *Buhrmester, H. C. | La Fayette | Tippecanoe |
| Buikstra, C. R. | Evansville | Vanderburgh |
| Bullard, Mattie J. | Gary | Lake |
| Bulson, Eugene L. | Fort Wayne | Allen |
| Bunch, Rollin H. | Muncie | Delaware-Blackford |
| *Bundy, Chester Merle | Salem | Washington |
| *Bunge, Clarence E. | Logansport | Cass |
| Bunker, L. Z. | N. Manchester | Wabash |
| Burcham, J. B. | Gary | Lake |
| Burk, James M. | Decatur | Adams |
| Burke, Homer L. | Bremen | Marshall |
| *Burkhardt, B. A. | Tipton | Tipton |
| Burkle, J. C. | La Fayette | Tippecanoe |
| *Burman, Richard G. | Jeffersonville | Clark |
| *Burnett, Arthur B. | New Castle | Henry |
| Burns, Elizabeth (H) | Fort Wayne | Allen |
| Burns, Paul E. | Montpelier | Delaware-Blackford |
| Burress, B. O. | Washington | Daviess-Martin |
| Burris, F. L. | Michigan City | La Porte |
| Burroughs, C. A. | Frankfort | Clinton |
| Burrous, E. Lee | Peru | Miami |
| *Burton, F. H. | Indianapolis | Marion |
| Bush, Hargis R. | Cannelton | Perry |

| Name | City | County |
|---|---|---|
| Bussard, C. F. | South Bend | St. Joseph |
| Butler, Raymond | Beech Grove | Marion |
| Butman. W. C. | Hebron | Porter |
| Butterfield, Robt. M. | Muncie | Delaware-Blackford |
| Buttz. Rose J. | Indianapolis | Marion |
| Byers, Norman R. | Bedford | Lawrence |
| Byrn, H. W. | New Albany | Floyd |
| *Byrne, Basil | New Albany | Floyd |
| Cabell, A. L. (H) | Terre Haute | Vigo |
| *Cacia, John J. | Evansville | Vanderburgh |
| Cahal, E. E. | Indianapolis | Marion |
| Cahn, Hugo M. | Indianapolis | Marion |
| Caldwell, William C. | Evansville | Vanderburgh |
| Call, E. B. | Knightstown | Henry |
| Call, H. F. | Indianapolis | Marion |
| *Callaghan, W. C. | Greensburg | Decatur |
| *Callahan, R. H. | East Chicago | Lake |
| *Calvert, R. R. | West Lafayette | Tippecanoe |
| Calvin, Jessie C. | Fort Wayne | Allen |
| Cameron, D. F. | Fort Wayne | Allen |
| *Campagna, E. A. | East Chicago | Lake |
| Campbell, J. A. | Indianapolis | Marion |
| Campbell, P. A. | Richmond | Wayne-Union |
| Canada, Clement L. | Logansport | Cass |
| Canaday, C. E. | New Castle | Henry |
| Canaday, J. W. | Indianapolis | Marion |
| Caplin, Irvin | Indianapolis | Marion |
| *Caplin, S. S. | Indianapolis | Marion |
| *Carbone, J. A. | Gary | Lake |
| Carey, W. W. (H) | Fort Wayne | Allen |
| Carlberg, D. L. | Jeffersonville | Clark |
| Carleton, E. H. | East Chicago | Lake |
| Carlo, Ernest R. | Fort Wayne | Allen |
| Carlo, J. F. | Hammond | Lake |
| Carlson, E. A. | Peru | Miami |
| *Carlson, Norman R. | Michigan City | La Porte |
| Carlyle, Ivan E. | Michigantown | Clinton |
| Carmichael, C. S. | Seelyville | Vigo |
| Carmody, R. F. | Gary | Lake |
| Carneal, Thomas E. | Winamac | Pulaski |
| Carney, C. E. (H) | Delphi | Carroll |
| Carney, J. T. | Jeffersonville | Clark |
| Carney, John C. | Monticello | Tippecanoe |
| Carpenter, G. C. | Terre Haute | Vigo |
| Carpenter, J. L. | Alexandria | Madison |
| Carpentier, Harry F. | Princeton | Gibson |
| Carrel, Francis E. | Indianapolis | Marion |
| *Carson, Wayne | Indianapolis | Marion |
| Carter, F. R. Nicholas | South Bend | St. Joseph |
| Carter, James C. | Indianapolis | Marion |
| Carter, J. V. | Tipton | Tipton |
| Carter, L. D. | Indianapolis | Marion |
| Carter, Oren E. | Indianapolis | Marion |
| Cartwright, E. L. | Fort Wayne | Allen |
| Casebeer, P. B. | Clinton | Parke-Vermillion |
| *Caseley, Donald F. | Indianapolis | Marion |
| Casey, Stanley M. | Huntington | Huntington |
| Casper, Joseph | Jasper | Dubois |
| Casper, J. P. | Jasper | Dubois |
| Cassady, J. V. | South Bend | St. Joseph |
| Cassidy, John L. | Evansville | Vanderburgh |
| *Caton, J. R. | South Bend | St. Joseph |
| Catlett, M. B. | Fort Wayne | Allen |
| Cavins, A. W. | Terre Haute | Vigo |
| Caylor, Harold D. | Bluffton | Wells |
| Caylor, Truman E. | Bluffton | Wells |
| Challman, W. B. | Mount Vernon | Posey |
| *Chambers, A. R. | Fort Wayne | Allen |
| *Chambers, L. B. | Union City | Randolph |
| Chandler, L. H. | Millersburg | Elkhart |
| Charles, Etta (H) | Anderson | Madison |
| *Chattin, V. J. | Washington | Daviess-Martin |
| *Chavinson, Benj. F. | Decatur | Adams |
| Chen, K. K. | Indianapolis | Marion |
| Cheney, F. D. | Indianapolis | Marion |
| Chester, H. R. | Fort Wayne | Allen |
| Chevigny, J. J. | Gary | Lake |
| Childlaw, B. W. | Hammond | Lake |
| Childs, A. G. W. | Madison | Jefferson |
| *Childs, Wallace E. | Princeton | Gibson |
| Chittick, A. G. | Frankfort | Clinton |
| Christman, Robt. A. | Muncie | Delaware-Blackford |
| Christophel, Verna | Mishawaka | St. Joseph |
| Christophel, W. B. | Mishawaka | St. Joseph |
| Clancy, J. F. | Hammond | Lake |
| Clapp, Fred R. | South Bend | St. Joseph |
| Clark, C. M. | Oakland City | Gibson |
| Clark, C. P. | Indianapolis | Marion |
| Clark, Cyrus J. | Indianapolis | Marion |
| Clark, Fred O. | Syracuse | Elkhart |
| Clark, Ivan A. | Paoli | Orange |
| *Clark, L. J. | Indianapolis | Marion |
| Clark, M. E. | Cambridge City | Wayne-Union |
| Clark, Stanley A. | South Bend | St. Joseph |
| *Clark, Wm. H. | South Bend | St. Joseph |
| Clark, W. R. | Fort Wayne | Allen |
| Clarke, Elton R. | Kokomo | Howard |
| Clauser, A. C. | Delphi | Carroll |
| Clauser, E. H. | Muncie | Delaware-Blackford |
| Clawson, J. C. | Richmond | Wayne-Union |
| *Clements, A. F. | Evansville | Vanderburgh |
| *Clevenger, J. H. | Muncie | Delaware-Blackford |
| Cline, George | Muncie | Delaware-Blackford |
| *Close, W. D. | Indianapolis | Marion |
| *Clunie, Wm. A. | | Harrison |
| Coble, F. H. | Richmond | Wayne-Union |
| Coble, R. R. | Indianapolis | Marion |
| Cochran, R. B. | Vincennes | Knox |
| Cockrum, Wm. M. | Evansville | Vanderburgh |
| Cody, B. L. | Evansville | Vanderburgh |
| *Cogswell, H. D. | Whiting | Lake |
| *Cohen, B. B. | East Chicago | Lake |
| *Cohen, B. W. | Indianapolis | Marion |
| *Cohen, Morris | Mitchell | Lawrence |
| Cohn, Phillip | New Albany | Floyd |
| Cole, A. V. | Hammond | Lake |
| *Cole, Alfred J. | W. Lafayette | Tippecanoe |
| Cole, Ira | La Fayette | Tippecanoe |
| Cole, R. E. | Muncie | Delaware-Blackford |
| *Cole, Wm. L. | Evansville | Vanderburgh |
| Coleman, H. G. | Odon | Daviess-Martin |
| Coleman, W. H. | Evansville | Vanderburgh |
| Coleman, Wm. S. | Rushville | Rush |
| Colglazier, Donald L. | Salem | Washington |
| Colglazier, G. G. | Leipsic | Orange |
| *Colip, George | South Bend | St. Joseph |
| Collett, G. A. | Crawfordsville | Montgomery |
| Collings, T. J. | Rockville | Parke-Vermillion |
| Collins, A. W. | Anderson | Madison |
| Collins, Hubert L. | Indianapolis | Marion |
| Collins, J. N. | Indianapolis | Marion |
| Combs, Charles N. | Terre Haute | Vigo |
| *Combs, Herman | Evansville | Vanderburgh |
| Combs, John H. | Evansville | Vanderburgh |
| *Combs, Nelson B. | Mulberry | Clinton |
| Combs, Pearl B. | Evansville | Vanderburgh |
| Combs, Stuart R. | Terre Haute | Vigo |
| Comer, Charles W. | Mooresville | Morgan |
| Comer, J. E. | Mooresville | Morgan |
| Comer, Kenneth E. | Mooresville | Morgan |
| Compton, C. B. | Frankfort | Clinton |
| *Compton, George | Tipton | Tipton |
| Compton, Silas M. | South Bend | St. Joseph |
| *Compton, Walter A. | Elkhart | Elkhart |
| *Comstock, Glenn E. | Gary | Lake |
| Condit, David H. | South Bend | St. Joseph |
| Conger, Elizabeth | Indianapolis | Marion |
| Congleton, G. C. | Terre Haute | Vigo |
| Conklin, R. L. | Elkhart | Elkhart |
| Conley, John E. | Fort Wayne | Allen |
| Conley, Joseph L. | Indianapolis | Marion |
| Conley, T. M. | Kokomo | Howard |
| *Connell, P. S. | Plymouth | Marshall |
| Connelly, J. J. | Terre Haute | Vigo |
| Conner, D. N. | Markleville | Madison |
| Conner, T. E. | Freetown | Jackson |
| *Connerley, M. L. | Indianapolis | Marion |
| Connoy, Andrew F. | Westfield | Hamilton |
| Conover, Earl | Evansville | Vanderburgh |
| Conrad, E. M. | Anderson | Madison |
| Conway, Chester C. | Indianapolis | Marion |
| Conway, Glenn | Indianapolis | Marion |
| Cook, C. J. (H) | Indianapolis | Marion |
| *Cook, Charles E. | No. Manchester | Wabash |
| Cook, E. C. | Madison | Jefferson |
| Cook, G. M. | Hammond | Lake |
| *Cook, Norman R. | Indianapolis | Marion |
| Cooksey, Thomas L. | Crawfordsville | Montgomery |
| Coomes, M. Joseph | Shelbyville | Shelby |
| *Cooney, Charles J. | Fort Wayne | Allen |
| Coons, John D. | Lebanon | Boone |
| *Cooper, George W. | Michigan City | LaPorte |
| Cooper, H. L. | South Bend | St. Joseph |
| Cooper, Leo Kenneth | Gary | Lake |
| Cooper, Ross A. | Carmel | Hamilton |
| Cooper, Thomas L. | Logansport | Cass |
| Copeland, C. C. (H) | North Madison | Jefferson |
| Copeland, G. W. | Vevay | Switzerland |
| Copeland, S. J. | Indianapolis | Marion |
| *Corboy, Philip | Valparaiso | Porter |
| Corcoran, Patrick J. V. | Evansville | Vanderburgh |
| *Cormican, Herbert L. | Elkhart | Elkhart |
| *Cornacchione, M. | Indianapolis | Marion |
| Cornell, Beaumont S. | Fort Wayne | Adams |
| Cortese, Thomas A. | Indianapolis | Marion |
| *Cotter, E. R. | East Chicago | Lake |
| Cottingham, C. E. (H) | Indianapolis | Marion |
| Cotton, Perry | Elwood | Madison |
| Cotton, S. M. | Goldsmith | Tipton |
| Couison, S. B. | Waldron | Shelby |
| Coultas, P. J. | Tell City | Perry |
| *Covalt, Donald A. | Muncie | Delaware-Blackford |
| Covalt, Nila | Muncie | Delaware-Blackford |
| *Covalt, Wendell E. | Muncie | Delaware-Blackford |
| Covell, H. M. | Auburn | De Kalb |
| Cox, C. E. | Indianapolis | Marion |
| Cox, H. Bailey | Indianapolis | Marion |
| Cox, Leon T. | Fountain City | Wayne-Union |
| *Cox, W. T. | La Fayette | Tippecanoe |
| Coyner, A. B. | La Fayette | Tippecanoe |
| Crabbe, Violet | Wolcott | Tippecanoe |
| Crabtree, L. R. | Columbus | Bartholomew |
| Craft, K. L. | Indianapolis | Marion |
| Craft, William F. | Linton | Greene |
| Craig, R. A. | Kokomo | Howard |
| *Craig, Robert A. | Indianapolis | Marion |
| *Crain, James W. | St. Meinrad | Spencer |
| Cramp, Arthur J. (H) | Hendersonville, N. C. | Porter |
| Crampton, C. C. | Delphi | Carroll |
| Crane, Albert L. | Evansville | Vanderburgh |
| Crawford, W. G. | Terre Haute | Vigo |
| Creel, Donald | Angola | Steuben |
| Crimm, Paul D. | Evansville | Vanderburgh |
| Cring, George | Portland | Jay |
| *Cripe, E. P. | Redkey | Jay |
| Crockett, F. S. | La Fayette | Tippecanoe |
| Crossland, Steward H. | Gary | Lake |
| Crowder, James H., Jr. | Sullivan | Sullivan |
| Crowder, J. R. | Sullivan | Sullivan |
| Crum, Marion M. | Angola | Steuben |
| Culbertson, C. S. | South Bend | St. Joseph |
| Culbertson, Clyde G. | Indianapolis | Marion |
| *Cullen, P. K. | Indianapolis | Marion |
| Cullnane, C. W. | Evansville | Vanderburgh |
| Culmer, W. N. | Bloomington | Monroe |
| Culp, John E. | Fort Wayne | Allen |
| Cummings, D. J. | Brownstown | Jackson |
| Cunningham, J. M. | Indianapolis | Marion |
| Cure, Elmer T. | Muncie | Delaware-Blackford |
| Curry, Claude A. | Terre Haute | Vigo |
| Curtner, M. L. | Vincennes | Knox |
| *Cushman, J. B. | Gary | Lake |
| Custer, E. W. | South Bend | St. Joseph |
| Cuthbert, F. S. | Kokomo | Howard |
| *Cuthbert, M. P. | Kokomo | Howard |
| Dahling, C. W. | New Haven | Allen |
| Dailey, J. E. | Terre Haute | Vigo |
| *Dainko, A. J. | Whiting | Lake |
| Dale, J. W. | Chesterton | Porter |
| Dalton, John E. | Indianapolis | Marion |
| Dalton, Naomi | Bloomington | Monroe |
| Dancer, C. R. | Fort Wayne | Allen |
| Dando, George H. | Hartford City | Delaware-Blackford |
| Daniel, J. C. | Indianapolis | Marion |

| Name | City | County |
|---|---|---|
| Danieleski, L. J. | Gary | Lake |
| Daniels, E. O. | Marion | Grant |
| Daniels, G. R. | Marion | Grant |
| Daniels, Robert E. | Decatur | Adams |
| Danruther, C. B. | La Porte | La Porte |
| Dare, Lee A. | Jeffersonville | Clark |
| Darling, Dorothy | South Bend | St. Joseph |
| Darroch, S. C. | Caynga | Parke-Vermillion |
| Daubenheyer, M. F. | Charlestown | Ripley |
| *Daugherty, F. N. | Crawfordsville | Montgomery |
| *Daves, W. L. | Evansville | Vanderburgh |
| Davidson, N. Cort | Indianapolis | Marion |
| Davidson, Wm. D. | Evansville | Vanderburgh |
| Davidson, W. R. | Evansville | Vanderburgh |
| Davis, Alice H. | Hammond | Lake |
| Davis, Carl M. | Valparaiso | Porter |
| Davis, D. F. | New Albany | Floyd |
| Davis, E. C. | Muncie | Delaware-Blackford |
| *Davis, George D. | Indianapolis | Marion |
| Davis, George H. | Union City | Randolph |
| Davis, J. A. | Flat Rock | Shelby |
| Davis, John A. | Indianapolis | Marion |
| *Davis, J. M. | Indianapolis | Marion |
| Davis, John C. | Logansport | Cass |
| *Davis, Joseph B. | Marion | Grant |
| Davis, L. H. | Mentone | Kosciusko |
| Davis, M. S. | Marion | Grant |
| Davis, Marvin R. | Columbus | Bartholomew |
| Davis, Neal | Lowell | Lake |
| *Davis, Parvin M. | New Albany | Floyd |
| Davis, Richard | Marion | Grant |
| Davisson C. V. | Williamsport | Fountain-Warren |
| Day, C. W. | Indianapolis | Marion |
| Day, George H. | New Albany | Floyd |
| Day, John | Indianapolis | Marion |
| *Day, W. D. C. | Seymour | Jackson |
| Deal, Eleanor H. | Indianapolis | Marion |
| *Dean, Donald I. | Rushville | Rush |
| Dean, Michael F. | Indianapolis | Marion |
| Deardorff, O. M. | Muncie | Delaware-Blackford |
| *Dearmin, R. M. | Indianapolis | Marion |
| *DeArmond, Murray | Indianapolis | Marion |
| Decker, H. B. | Terre Hante | Vigo |
| DeDario, L. M. | Elkhart | Elkhart |
| *Deems, M. B. | Huntington | Huntington |
| Deen, H. H. | Leavenworth | Crawford |
| Deer, Blan F. | Indianapolis | Marion |
| Deever, J. W. | Indianapolis | Marion |
| *DeGrazia, E. J. | Valparaiso | Porter |
| *De Lawter, Pierre | Indianapolis | Marion |
| *DeLawter, Hilbert H. | Danville, Illinois | Marion |
| DeLong, C. A. | Gary | Lake |
| DeLong, O. A. (H) | Elizabethtown | Bartholomew |
| De Motte, C. Bowen | Greenwood | Marion |
| *DeMotte, R. A. | Bloomington | Monroe |
| DeNaut, J. F. | Knox | Starke |
| DeNaut, J. L. | Hamlet | Starke |
| Denman, R. D. | Helmer | Steuben |
| Denny, Edgar C. | Richmond | Wayne-Union |
| Denny, Frank T. | Ladoga | Montgomery |
| Denny, Fred C. | Madison | Jefferson |
| Denny, J. W. | Indianapolis | Marion |
| *Denton, Larkin D. | Greentown | Howard |
| *Denzer, E. K. | Evansville | Vanderburgh |
| Denzer, Wm. Oliver | Evansville | Vanderburgh |
| Deputy, E. M. | Dugger | Sullivan |
| *Deputy, Rolland | Indianapolis | Marion |
| Derbyshire, John E. | Van Buren | Grant |
| Derhammer, G. L. | Brookston | Tippecanoe |
| Derian, M. H. | Gary | Lake |
| Dester, Herbert E. | Jagdeeshpur, India | Marion |
| DeTar, G. B. | Winslow | Pike |
| Detrick, H. W. | Hammond | Lake |
| *Dettloff, Frederick | Cloverdale | Putnam |
| *Deutsch, Wm. | Muncie | Delaware-Blackford |
| DeWees, Dwight L. | Indianapolis | Marion |
| Dewey, Fred N. (H) | Elkhart | Elkhart |
| Dewey, George W. | Pine Village | Tippecanoe |
| DeWitt, C. H. | Valparaiso | Porter |
| Diamond, Leo | Marion | Grant |
| Diamondstein, Jos. | Calumet City, Ill. | Lake |
| *Dian, A. J. | Gary | Lake |
| Dian, Julia G. Kuzmitz | Gary | Lake |
| Dick, Jack | Huntington | Huntington |
| *Dickens, K. L. | Martinsville | Morgan |
| *Dickinson, G. A. | Petersburg | Pike |
| *Dickson, D. D. | Letts | Decatur |
| Dieckman, Herbert S. | Evansville | Vanderburgh |
| Diefendorf, Charles F. | Evansville | Vanderburgh |
| Diehman, F. C. | Fulton | Fulton |
| Dierolf, E. J. | Gary | Lake |
| Dieter, Wm. J. | Indianapolis | Marion |
| Dietl, E. L. | South Bend | St Joseph |
| Dilley, Fred C. | Brazil | Clay |
| Dillinger, George R. | Thomasville, Georgia | Orange |
| Dillman, Carl E. | Corydon | Harrison |
| Dilts, Robert | Indianapolis | Marion |
| *Dingle, Paul | Richmond | Wayne-Union |
| Dininger, W. S. | Winchester | Randolph |
| *Dittmer, J. E. | Valparaiso | Porter |
| Dittmer, S. E. | Kouts | Porter |
| *Dittmer, Thomas L. | Kouts | Porter |
| Ditton, I. W. | Fort Wayne | Allen |
| Dixon, Rex | Anderson | Madison |
| Dobbins, Thomas | Evansville | Vanderburgh |
| Dodd, Robert R. | Evansville | Vanderburgh |
| *Dodds, James U. | Hartford City | Delaware-Blackford |
| Dodds, Wemple | Crawfordsville | Montgomery |
| Doenges, James L. | Anderson | Madison |
| Dollens, Claude | Oolitic | Lawrence |
| Dome, H. S. | Tell City | Perry |
| Donahue, C. M. | Carmel | Hamilton |
| Donahue, G. R. | La Fayette | Tippecanoe |
| Donato, Albert M. | Indianapolis | Marion |
| Douchess, J. C. | Gary | Lake |
| *Donovan, S. J. | Michigan City | La Porte |
| Dorman, W. L. | Indianapolis | Marion |
| Dorrance, T. O. | Bluffton | Wells |
| Doty, J. R. | Gary | Lake |
| Douglas, G. R. | Valparaiso | Porter |
| *Douglas, William T. | Lafayette | Tippecanoe |
| Dowell, E. H. | Rockville | Parke-Vermillion |
| *Dragoo, Farrol | Middletown | Madison |
| *Drake, John C. | Anderson | Madison |
| Draper, M. H. | Fort Wayne | Allen |
| Draper, R. H. | Bremen | Marshall |
| Dreyer, Ralph W. | Knightstown | Henry |
| *Drohan, E. P. | Lawrenceburg | Dearborn-Ohio |
| Druley, G. N. | Kokomo | Howard |
| Dubois, Franklin T. | Liberty | Wayne-Union |
| Dubois, R. B. | West Point | Tippecanoe |
| *Duckworth, James W. | San Francisco, Calif. | Marion |
| Dudding, J. E. | Hope | Bartholomew |
| Duemling, Arnold H. | Fort Wayne | Allen |
| *Duemling, W. W. | Fort Wayne | Allen |
| Dugan, Thomas J. | Indianapolis | Marion |
| Dugan, Wm. M. | Indianapolis | Marion |
| Duggan, J. A. | South Bend | St. Joseph |
| Duke, B. E. | Decatur | Adams |
| Dukes, David A. | Tell City | Perry |
| Dukes, F. M. | Dugger | Sullivan |
| *Dukes, Richard | Dugger | Sullivan |
| Duncan, J. S. | Gary | Lake |
| Duncan, Wm. F. (H) | Aurora | Dearborn-Ohio |
| Dunham, W. F. | Kempton | Tipton |
| Dunlap, Harold | Indianapolis | Marion |
| Dunn, F. W. | Muncie | Delaware-Blackford |
| Dunning, L. M. | Indianapolis | Marion |
| Dupes, L. E. | Hobart | Lake |
| *Durkee, M. S. | Evansville | Vanderburgh |
| Dusard, Joseph C. | Bedford | Lawrence |
| Dutchess, C. T. | Galveston | Cass |
| Dutton, H. H. | Martinsville | Morgan |
| DuVall, W. N. | Mishawaka | St. Joseph |
| *Dyar, E. W., Jr. | Indianapolis | Marion |
| Dycus, W. A. | Evansville | Vanderburgh |
| *Dyer, G. W. | Terre Haute | Vigo |
| Dykhuizen, T. A. | Frankfort | Clinton |
| *Eades, Ralph C. | Valparaiso | Porter |
| *Eastman, J. R. Jr. | Indianapolis | Marion |
| *Eaton, E. R. | Indianapolis | Marion |
| Eaton, L. D. | Indianapolis | Vanderburgh |
| Eaton, M. J. | La Fayette | Tippecanoe |
| Eberhart, L. L. | Angola | Steuben |
| Eberly, K. C. | Fort Wayne | Allen |
| Ebert, J. Wayne | Indianapolis | Marion |
| Eberwein, J. H. | Indianapolis | Marion |
| Eby, Ida L. | Goshen | Elkhart |
| Echternacht, A. P. | Indianapolis | Marion |
| Edlavitch, B. M. | Fort Wayne | Allen |
| Edwards, Bernard | South Bend | St. Joseph |
| Edwards, E. T. | Vincennes | Knox |
| *Edwards, W. F. | New Albany | Floyd |
| Egan, B. W. | Logansport | Cass |
| *Egbert, H. L. | Indianapolis | Marion |
| Egbert, Roy | Indianapolis | Marion |
| Eggers, E. L. | Hammond | Lake |
| Eggers, H. W. | Hammond | Lake |
| Ehrich, W. S. | Evansville | Vanderburgh |
| Ehrman, C. D. | Rockport | Spencer |
| Eichelberger, W. W. | Evansville | Vanderburgh |
| Eicher, F. I. | Wakarusa | Elkhart |
| *Eicher, Palmer | Decatur | Adams |
| Eifert, E. E. | Loogootee | Daviess-Martin |
| Eikenberry, H. W. | Peru | Miami |
| *Eisaman, Jack L. | Bluffton | Wells |
| Eisamen, C. L. | Indianapolis | Marion |
| Eisenberg, D. A. | Hammond | Lake |
| Eisenlohr, Eugene | Terre Haute | Vigo |
| Eisterhold, John A. | Evansville | Vanderburgh |
| Eldridge, Gail E. | Indianapolis | Marion |
| Elledge, Ray | Hammond | Lake |
| Ellerbrook, George E. | Vevay | Switzerland |
| Elliott, John C. | Guilford | Dearborn-Ohio |
| Elliott, L. A. | Elkhart | Elkhart |
| Elliott, R. A. | Gary | Lake |
| Elliott, R. H. | Connersville | Fayette-Franklin |
| Ellis, Bert | Indianapolis | Marion |
| *Ellis, L. H. | Lebanon | Boone |
| *Ellis, S. R. | Versailles | Ripley |
| Ellison, Alfred | South Bend | St. Joseph |
| Elsner, L. W. | Seymour | Jackson |
| Elsten, A. W. | Lapel | Madison |
| Elston, L. W. | Fort Wayne | Allen |
| Elston, Ralph W. | Fort Wayne | Allen |
| Emenhiser, Donald C. | Darby, Pa. | St. Joseph |
| *Emenhiser, John L. | Woodburn | Allen |
| *Emery, Charles B. | Bedford | Lawrence |
| Emery, Charles H. (H) | Bedford | Lawrence |
| Emhardt, J. W. A. | Indianapolis | Marion |
| Emhardt, John T. | Indianapolis | Marion |
| *Emme, R. W. | Harlan | Allen |
| *Engel, E. L. | Evansville | Vanderburgh |
| *Engeler, J. E. | Indianapolis | Marion |
| *Engle, J. M. | Portland | Jay |
| Engle, Russell B. | Winchester | Randolph |
| *Englebert, W. F. | Fort Wayne | Allen |
| Engleman, H. K. | Georgetown | Floyd |
| English, C. H. (H) | Fort Wayne | Allen |
| English, H. E. | Rensselaer | Jasper-Newton |
| English, H. M. | Gary | Lake |
| English, J. P. | South Bend | St. Joseph |
| Engstrom, Robert B. | Michigan City | LaPorte |
| Ensminger, L. A. | Indianapolis | Marion |
| Entner, Charles L. | Connersville | Wayne-Union |
| Enzor, O. K. | Indianapolis | Marion |
| *Episcopo, A. R. | Mitchell | Lawrence |
| Epple, S. L. | Bristow | Perry |
| *Erdel, Milton W. | Frankfort | Clinton |
| Erehart, A. D. | Anderson | Madison |
| Erehart, M. G. | Huntington | Huntington |
| Ericksen, Lester G. | South Bend | St. Joseph |
| Ericson, H. L. | Windfall | Tipton |
| Ernst, Clifford | Indianapolis | Marion |
| Ernst, H. C. W. | East Chicago | Lake |
| Erwin, H. G. | Lagrange | Lagrange |
| Eshleman, L. H. | Marion | Grant |
| Estel, G. A. | Madison | Jefferson |
| *Estlick, R. E. | Fort Wayne | Allen |

| Name | City | County |
|---|---|---|
| *Ettl, Edward L | Indianapolis | Marion |
| Evans, R. M. | Russiaville | Howard |
| Everly, Ralph | Indianapolis | Marion |
| Evlston, J. B. | Huntington | Huntington |
| Fagaly, A. T. (H) | Lawrenceburg | Dearborn-Ohio |
| *Fagaly, W. J. | Lawrenceburg | Dearborn-Ohio |
| Faltin, Ladislaus | South Bend | St. Joseph |
| Farabee, Charles R. | North Judson | Starke |
| Fargher, F. M. | Michigan City | La Porte |
| Fargher, R. A. | La Porte | La Porte |
| Farnham, W. C. | South Bend | St. Joseph |
| Farrell, J. T. | Indianapolis | Marion |
| Farver, M. A. | Middlebury | Elkhart |
| Faul, Henry J. | Evansville | Vanderburgh |
| Faulkner, A. S. | Waynetown | Lagrange |
| Fausset, C. Basil | Indianapolis | Marion |
| Feerer, Donald J. | Michigan City | La Porte |
| *Fender, A. H. | Worthington | Greene |
| *Ferguson, A. N. | Fort Wayne | Allen |
| *Ferguson, Wm. B. | Indianapolis | Marion |
| Ferrara, Donald W. | Peru | Miami |
| Ferrara, S. J. | Peru | Miami |
| *Ferree, John W. | Indianapolis | Marion |
| Ferrell, Jesse E. | Fortville | Hancock |
| *Ferrell, Mars B. | Fortville | Hancock |
| *Ferry, John L. | Whiting | Lake |
| Ferry, P. W. | Kokomo | Howard |
| Fessler, G. S. | Rising Sun | Dearborn-Ohio |
| Fichman, A. M. | Fort Wayne | Allen |
| Fickas, Dallas | Evansville | Vanderburgh |
| Filipek, W. J. | South Bend | St. Joseph |
| Fipp, August L. | Rome City | Noble |
| *Firestein, Ben | South Bend | St. Joseph |
| Fish, C. M. | South Bend | St. Joseph |
| Fish, Edson C. | South Bend | St. Joseph |
| Fisher, Albert | North Judson | La Porte |
| Fisher, C. N. | La Porte | La Porte |
| *Fisher, Henry | Marion | Grant |
| Fisher, John E. | Clarksburg | Decatur |
| *Fisher, K. B. | Indianapolis | St. Joseph |
| Fisher, Lawrence F. | South Bend | St. Joseph |
| Fisher, Pierre J. | Marion | Grant |
| Fisher, Walter S. | Columbus | Bartholomew |
| Fisk, Frank B. | Indianapolis | Marion |
| Fitzgerald, Brice E. | Logansport | Marion |
| Fitzpatrick, H. W. | Elwood | Madison |
| *Fitzsimmons, E. L. | Evansville | Vanderburgh |
| *Flack, Russell A. | La Fayette | Tippecanoe |
| Flanagan, E. P. | Walton | Cass |
| Flannigan, H.F. | Lagrange | Lagrange |
| Flanigan, M. B. | Lafayette | Tippecanoe |
| *Fleetwood, R. A. | Nappanee | Elkhart |
| Fleischer, J. C. | East Chicago | Lake |
| Fleming, C. F. | Elkhart | Elkhart |
| *Fleming, Justus M. | Elkhart | Elkhart |
| Fletcher, Charles F. | Sunman | Dearborn-Ohio |
| *Flick, John J. | Indianapolis | Marion |
| *Flora, Joseph O. | Indianapolis | Marion |
| *Folck, J. K. | Princeton | Gibson |
| *Folkening, N. C. | Detroit, Mich. | Marion |
| Foltz, Lloyd E. | Brownsburg | Hendricks |
| Folz, C. J. | Evansville | Vanderburgh |
| Foreman, Harry L. | Indianapolis | Marion |
| Foreman, W. A. | Brookville | Fayette-Franklin |
| Forry, Frank | Indianapolis | Marion |
| Forster, N. K. | Hammond | Lake |
| Forsyth, D. H. | Terre Haute | Vigo |
| Fosbrink, E. L. | Syracuse | Elkhart |
| Fosler, D. W. | Indianapolis | Marion |
| *Fouts, Joseph R. | English | Crawford |
| *Fouts, Paul J. | Indianapolis | Marion |
| Fox, C. Philip | Washington | Daviess-Martin |
| Fox, F. H. | Hammond | Lake |
| Fox, M. S. | Bicknell | Knox |
| Fox, R. H. | Bicknell | Knox |
| Foy, H. W. | Fort Wayne | Allen |
| Frank, J. R. | Valparaiso | Porter |
| Frank, L. L. | South Bend | St. Joseph |
| Franklin, Ernest J. | Indianapolis | Marion |
| Franklin, Philip L. | Gary | Lake |
| Frankowski, Clementine | Whiting | Lake |
| *Frantz, Mount E. | Danville | Hendricks |
| Frasch, M. G. | La Fayette | Tippecanoe |
| Frash, De Von W. | South Bend | St. Joseph |
| Freed, James C. | Attica | Fountain-Warren |
| Freed, J. E. | Terre Haute | Vigo |
| *Freed, John E., Jr. | Terre Haute | Vigo |
| Freeman, F. M. | Goshen | Elkhart |
| Freireich, Kal | South Bend | St. Joseph |
| French, Virgil | Riley | Vigo |
| French, Wm. G. | Evansville | Vanderburgh |
| Friedrich, L. M. | Hobart | Lake |
| Frith, Gladys D. | South Bend | St. Joseph |
| Frith, Louis G. | South Bend | St. Joseph |
| Fritsch, L. E. | Evansville | Vanderburgh |
| *Fromhold, Willis A. | Indianapolis | Marion |
| *Fry, Robert D. | Indianapolis | Marion |
| Frybarger, S. S. | Converse | Miami |
| *Fuelling, James L. | Newburgh | Warrick |
| *Fullerton, R. L. | Indianapolis | Marion |
| *Funk, John W. | Muncie | Delaware-Blackford |
| Funk, V. A. | Vincennes | Knox |
| Funkhouser, A. G. | Indianapolis | Marion |
| Funkhouser, Elmer | Indianapolis | Marion |
| Furgason, Paul C. | Indianapolis | Marion |
| Furniss, S. A. | Indianapolis | Marion |
| Fuson, W. J. | Greencastle | Putnam |
| Fyfe, M. B. | Valparaiso | Porter |
| Gabe, Harry E. (H) | Indianapolis | Marion |
| Gabe, Wm. E. | Indianapolis | Marion |
| Gabhart, J. H. | Elberfeld | Warrick |
| Gable, H. B. | Monticello | White |
| Gaddy, Euclid T. | Indianapolis | Marion |
| Galante, Vincent J. | Chicago, Ill. | Lake |
| Galbreath, R. S. | Huntington | Huntington |
| Galbreth, J. P. | Burnettsville | White |
| Gallup, Palmer R. | Indianapolis | Marion |
| Gambill, Wm. D. | Indianapolis | Marion |
| Gannon, G. W. | Gary | Lake |
| *Ganser, Richard A. | Mishawaka | St. Joseph |
| Gante, H. W. | Anderson | Madison |
| *Ganz, Max | Marion | Grant |
| Garber, E. C. | Dunkirk | Jay |
| *Garber, J. Neill | Indianapolis | Marion |
| Garber, Paul A. | South Whitley | Whitley |
| Garceau, George J. | Indianapolis | Marion |
| *Gardner, Buckman | Indianapolis | Marion |
| Gardner, M. D. | Michigan City | La Porte |
| *Gardner, R. A. | Michigan City | La Porte |
| *Garfield, M. D. | Hobart | Lake |
| Garland, Edgar A. | Evansville | Vanderburgh |
| *Garling, L. C. | Muncie | Delaware-Blackford |
| Garner, William | Indianapolis | Marion |
| *Garner, W. Stanley | Indianapolis | Marion |
| *Garner, Wm. H. | New Albany | Floyd |
| Garrett, John D. | Indianapolis | Marion |
| Garrison, Leon J. | Gas City | Grant |
| Garton, H. W. | Fort Wayne | Allen |
| Gastineau, F. M. | Indianapolis | Marion |
| Gateh, W. D | Indianapolis | Marion |
| Gates, George E. | South Bend | St. Joseph |
| Gaul, L. Edward | Evansville | Vanderburgh |
| Gaunt, Everett W. | Alexandria | Madison |
| Gauss, Julius H. P. | Indianapolis | Marion |
| *Gehres, R. W. | Shelbyville | Shelby |
| Geider, Roy A. | Indianapolis | Marion |
| Geiger, Dillon | Bloomington | Monroe |
| Geisel, E. E. | Gary | Lake |
| Geisinger, L. N. | Auburn | De Kalb |
| *Gentile, John P. | New Albany | Floyd |
| *George, Charles L. | Indianapolis | Marion |
| *Gerding, William J. | Fort Wayne | Allen |
| Gerrish, D. A. | Terre Haute | Vigo |
| Gerrish, W. D. | Clinton | Parke-Vermillion |
| *Gery, Richard E. | La Fayette | Tippecanoe |
| Gessler, W. F. | Fort Wayne | Allen |
| Gevirtz, M. B. | Hammond | Lake |
| Gibbs, Charles | Greenfield | Hancock |
| Gibbs, E. R. | Wilkinson | Hancock |
| Gibbs, Joseph W. | Danville | Hendricks |
| Gibson, J. J. (H) | Alexandria | Madison |
| Gick, Herman | Indianapolis | Marion |
| Gifford, F. E. | Indianapolis | Marion |
| Gilbert, Ivan | Terre Haute | Vigo |
| Gilkison, J. S. | Shoals | Daviess-Martin |
| Gill, B. P. | Evansville | Vanderburgh |
| *Gill, D. D. | Greenfield | Hancock |
| Gillespie, C. E. | Seymour | Jackson |
| *Gillespie, C. F. | Indianapolis | Marion |
| Gillespie, G. R. | Brownstown | Jackson |
| *Gillespie, J. E. | Indianapolis | Marion |
| Gillespie, J. F. (H) | Greencastle | Putnam |
| *Gilliatt, J. P. | Salem | Washington |
| *Gilliom, Luther A. | Indianapolis | Marion |
| Gillum, John R. | Terre Haute | Vigo |
| Gilman, M. M. | South Bend | St. Joseph |
| Gilmore, L. L. | Vincennes | Knox |
| Gilmore, R. A. | Michigan City | La Porte |
| Gingerick, C. M. | Liberty Center | Wells |
| Giordano, A. S. | South Bend | St. Joseph |
| Giorgi, Antonio (H) | Gary | Lake |
| *Gipe, W. W. | Tuscon, Ariz. | Howard |
| *Gitlin, Max M. | Bluffton | Wells |
| *Gitlin, Wm. A. | Bluffton | Wells |
| Glackman, J. C., Sr. | Rockport | Spencer |
| *Glackman, J. C., Jr., | Rockport | Spencer |
| *Gladstone, N. H. | Fort Wayne | Allen |
| Glaser, E. M. | Brookville | Fayette-Franklin |
| Glaser, R. E. | Brookville | Fayette-Franklin |
| Glass, R. L. | Indianapolis | Marion |
| Glendening, J. L. | Indianapolis | Marion |
| Glenn, Fred C. | Tell City | Perry |
| Glenn, L. F. | Ramsey | Harrison |
| Glick, O. E. | Kentland | Jasper-Newton |
| Glock, H. E. | Fort Wayne | Allen |
| Glock, M. E. | Fort Wayne | Allen |
| Glock, Wayne R. | Fort Wayne | Allen |
| Gobbel, N. E. | English | Crawford |
| Goebel, Joan M. | Evansville | Vanderburgh |
| Godersky, Lois | Flora | Carroll |
| Goethals, Charles J. | Mishawaka | St. Joseph |
| Goldstone, Adolph | Gary | Lake |
| Goldstone, Joseph | Gary | Lake |
| Goldthwaite, H. R. | Marion | Grant |
| Good, R. P. | Kokomo | Howard |
| *Goodman, H. T. | Terre Haute | Vigo |
| *Goodrich, Albert | Bloomington | Monroe |
| Goodwin, C. B. (H) | Kendallville | Noble |
| Goodwin, Caroline M. | Indianapolis | Marion |
| Goodwin, L. D. | Winslow | Pike |
| Goraczewski, Thaddeus | South Bend | St. Joseph |
| Gordin, Stanley | Connersville | Fayette-Franklin |
| Gordin, Stanton E. | Connersville | Fayette-Franklin |
| Gordon, J. L. | Wheeler | Porter |
| Gordon, J. M. | South Bend | St. Joseph |
| Goss, H. W. | Indianapolis | Marion |
| Gould, L. K. | Fort Wayne | Allen |
| Govorchin, Alexander | East Chicago | Lake |
| Gracy, Alice | South Bend | St. Joseph |
| Graessle, Harold P. | Seymour | Jackson |
| *Graf, John E. | Chicago, Ill. | Marion |
| *Graff, Jerome A. | Bloomington | Greene |
| Graham, A. B. | El Paso, Tex. | Marion |
| Graham, Cova R. | Bourbon | Marshall |
| *Graham, Thomas | La Fayette | Tippecanoe |
| Gramling, J. J. | Indianapolis | Marion |
| *Grandstaff, F. L. | Decatur | Adams |
| *Graves, J. W. | Indianapolis | Marion |
| Graves, Orville M. | Princeton | Gibson |
| Gray, D. E. | Crown Point | Lake |
| Gray, Leon | Martinsville | Morgan |
| Gray, Paul M. | Huntington | Huntington |
| Grayston, F. W. | Huntington | Huntington |
| Grayston, Wallace S. | Huntington | Huntington |
| Green, F. H., Jr. | Rushville | Rush |
| *Green, George F. | South Bend | St. Joseph |
| Green, John H. | North Vernon | Jennings |
| Green, Lowell M. | Rushville | Rush |
| Green, Myron H. | Indianapolis | Marion |
| Green, S. I. | St. Bernice | Parke-Vermillion |
| Green, Wm. L. | Pekin | Washington |
| Greene, Claude D. | Spencer | Owen |
| Greene, F. G. | Bloomingdale | Parke-Vermillion |
| *Greer, O. W. | Indianapolis | Marion |

| Name | City | County |
|---|---|---|
| *Gregg, Albert F. | Connersville | Fayette-Franklin |
| Greist, H. W. (H) | Monticello | White |
| *Greist, John | Indianapolis | Marion |
| Griest, O. E. | La Fayette | Tippecanoe |
| Griffin, J. P. | Chesterton | LaPorte |
| Griffis, V. C. | Richmond | Wayne-Union |
| Griffith, J. B. | Crawfordsville | Montgomery |
| *Griffith, James W. | Sheridan | Hamilton |
| Griffith, R. E. | Indianapolis | Marion |
| Grillo, Donald | South Bend | St. Joseph |
| Grimes, J. H. | Danville | Hendricks |
| *Griswold, W. R. | Indianapolis | Marion |
| Groman, H. C. | Hammond | Lake |
| *Gros, Hubert | Delphi | Carroll |
| *Gross, M. E. | Ladoga | Montgomery |
| Grosskreutz, Doris | Evansville | Vanderburgh |
| Grossman, W. L. | North Vernon | Jennings |
| Grossnickle, Geo. W. | Elkhart | Elkhart |
| Grosso, W. G. | East Chicago | Lake |
| Grove, E. G. | Shelbyville | Shelby |
| *Grzesk, Leo L. | Mishawaka | St. Joseph |
| Gudenkauf, Elton B. | Jeffersonville | Clark |
| *Guild, C. J. | Garrett | De Kalb |
| Gustafson, G. W. | Indianapolis | Marion |
| Gutelius, C. B. | Indianapolis | Marion |
| Guthrie, F. C. | Anderson | Madison |
| Gutierrez, F. A. | Gary | Lake |
| Gutstein, Richard R. | Kendallville | Noble |
| Gwaltney, L. F. | Roachdale | Putnam |
| Gwartney, Richard H. | Muncie | Delaware-Blackford |
| Gwin, M. D. | Rensselaer | Jasper-Newton |
| Habegger, Myron L. | Berne | Adams |
| Habermel, John F. | New Albany | Floyd |
| Habich, Carl | Indianapolis | Marion |
| Hack, E. C. | Hammond | Lake |
| Hadden, Claude E. | Indianapolis | Marion |
| Hade, Frederick L. | Bridgeport | Marion |
| Hadley, A. W. | La Fayette | Tippecanoe |
| *Hadley, David | Indianapolis | Marion |
| Hadley, Harvey | Richmond | Wayne-Union |
| Hadley, Murray N. | Indianapolis | Marion |
| *Haffner, H. G. | Fort Wayne | Allen |
| *Haggard, E. B. | Indianapolis | Marion |
| Hagie, F. E. | Richmond | Wayne-Union |
| Hahn, E. V. | Indianapolis | Marion |
| Haley, Paul E. | South Bend | St. Joseph |
| Hall, E. H. | Dunkirk | Delaware-Blackford |
| *Hall, Frank M. | La Fayette | Tippecanoe |
| Hall, O. A. | Muncie | Delaware-Blackford |
| Hall, T. C. | Medaryville | Pulaski |
| Hallam, F. T. | Indianapolis | Marion |
| *Halleck, H. J. | Winamac | Pulaski |
| Haller, Thomas C. | Williamsport | Fountain-Warren |
| Hamer, H. G. | Indianapolis | Marion |
| Hamilton, Alexander | Frankfort | Clinton |
| Hamilton, Antha A. | Shelburn | Sullivan |
| Hamilton, E. E. | Dayton | Tippecanoe |
| Hamilton, Guy W. | Madison | Jefferson |
| Hamilton, H. B. | Terre Haute | Vigo |
| Hamilton, J. R. | Mitchell | Lawrence |
| Hamilton, M. Luther | Newberry | Greene |
| Hamilton, O. G. | Bluffton | Wells |
| Hamilton, R. C. | East Chicago | Lake |
| *Hammersley, Geo. K. | Frankfort | Clinton |
| *Hammond, Keith | Paoli | Orange |
| *Hammond, Stanley M. | Portland | Jay |
| *Hancock, John G. | Indianapolis | Marion |
| *Hane, R. L. | Fort Wayne | Allen |
| Hanna, T. A. | Indianapolis | Marion |
| *Hannebaum, O. P. | Indianapolis | Marion |
| *Hansell, R. M. | Indianapolis | Marion |
| Hansen, A. H. | Hammond | Lake |
| Harcourt, A. K. | Indianapolis | Marion |
| Hardesty, K. C. | Fort Wayne | Allen |
| Hardin, W. E. | Ossian | Wells |
| Harding, M. Richard | Indianapolis | Marion |
| Harding, Myron S. | Indianapolis | Marion |
| Hardy, Charles F. | Kendallville | Noble |
| Hardy, John J. | North Liberty | St. Joseph |
| *Hare, E. H. | Indianapolis | Marion |
| Hare, John H. | Evansville | Vanderburgh |
| Hare, Laura | Indianapolis | Marion |
| Hargis, W. T. (H) | Tell City | Perry |
| Harkeom, H. E. | St. Paul | Decatur |
| Harkness, R. G. | Terre Haute | Vigo |
| *Harmon, C. J. | Richmond | Wayne-Union |
| Harmon, Gladys H. | Richmond | Wayne-Union |
| Harmon, Vachelle E. | South Bend | St. Joseph |
| Harmon, Wayne | Lynn | Randolph |
| Harold, A. H. | Indianapolis | Marion |
| Harold, N. E. | Indianapolis | Marion |
| Harris, B. W. | Gary | Lake |
| Harris, Carl B. | Indianapolis | Marion |
| *Harris, L. E. | La Fayette | Tippecanoe |
| Harris, Paul N. | Indianapolis | Marion |
| Harris, R. F. | Noblesville | Hamilton |
| Harris, W. L. | Evansville | Vanderburgh |
| Harrison, B. L. | New Castle | Henry |
| Harrison, Wm. H. (H) | Kokomo | Howard |
| Harshman, L. P. | Fort Wayne | Allen |
| *Harshman, Martin L | Colfax | Clinton |
| *Harstad, C. | Rockville | Parke-Vermillion |
| Hart, L. Paul | Evansville | Vanderburgh |
| Hart, Robert B. | Columbus | Bartholomew |
| *Hart, Wm. D. | Anderson | Madison |
| Hartley, C. A., Jr., | Evansville | Vanderburgh |
| Hartley, C. A. | Evansville | Vanderburgh |
| Hartz, F. Minton | Evansville | Vanderburgh |
| *Harvey, B. J. | La Fayette | Tippecanoe |
| Harvey, Harry C. | Fort Wayne | Allen |
| Harvey, R. J. | Zionsville | Boone |
| Harvey, Verne K. | Alexandria, Va. | Marion |
| *Hasewinkle, A. M. | Fort Wayne | Allen |
| Hash, John S. | Indianapolis | Marion |
| *Haslem, Ezra R. | Terre Haute | Vigo |
| *Haslem, John R. | Terre Haute | Vigo |
| Haslinger, C. J. | Indianapolis | Marion |
| Hassenmiller, Mart (H) | West Baden | Orange |
| Hatfield, B. F. | Indianapolis | Marion |
| *Hatfield, N. W. | Indianapolis | Marion |
| Hatfield, S. J. | Indianapolis | Marion |
| Hathaway, Clayton B. | Butler | De Kalb |
| *Hattendorf, A. P. | Fort Wayne | Allen |
| Hauss, A. P. | New Albany | Floyd |
| Havens, Edward D. | Cicero | Hamilton |
| Havens, Oscar | Cicero | Hamilton |
| *Havens, R. E. | Cicero | Hamilton |
| Havice, Jay F. | Fort Wayne | Allen |
| Hawes, J. K. | Columbus | Bartholomew |
| *Hawes, M. E. | Hartsville | Bartholomew |
| *Hawk, Edgar A. | New Palestine | Hancock |
| *Hawk, James H. | Indianapolis | Marion |
| *Hayes, J. J. | Fort Wayne | Allen |
| Hayes, T. R. | Muncie | Delaware-Blackford |
| Haymond, Joseph L. | South Bend | St. Joseph |
| *Hays, E. L. | Indianapolis | Marion |
| Hays, George R. | Richmond | Wayne-Union |
| Hazel, James T. (H) | Freedom | Owen |
| Hazinski, R. T. | Griffith | Lake |
| *Headley, L. M. | Lebanon | Boone |
| Heald, Walter | West Lebanon | Fountain-Warren |
| Healy, Wm. F. | Evansville | Vanderburgh |
| Heard, Albert | Evansville | Vanderburgh |
| *Heasty, Robert G. | Michigan City | LaPorte |
| Heberer, J. M. | Evansville | Vanderburgh |
| *Heck, M. C. | Jasper | Dubois |
| *Hedde, E. L. | Logansport | Cass |
| *Hedgcock, R. A. | Frankfort | Clinton |
| Hedrick, R. M. | Gary | Lake |
| Hefti, Karl | Evansville | Vanderburgh |
| Heilman, W. C. | New Castle | Henry |
| Heinrich, H. H. | Indianapolis | Marion |
| *Held, Albert H. | Huntingburg | Dubois |
| *Held, George A. | Jasper | Dubois |
| Heller, N. L. | Dunkirk | Jay |
| Heller, Oscar | Greenfield | Hancock |
| Helm, Karl G. | Shoals | Daviess-Martin |
| Helmen, H. W. | South Bend | St. Joseph |
| *Helper, Morton | Evansville | Vanderburgh |
| Henderson, Arvin | Ridgeville | Randolph |
| *Henderson, R. A. | Muncie | Delaware-Blackford |
| Hendricks, John W. | Indianapolis | Marion |
| Henley, Glenn | Fairmount | Grant |
| *Henry, Russell S. | Indianapolis | Marion |
| Henning, Carl | Hanover | Jefferson |
| Hepburn, C. K. | Indianapolis | Marion |
| Hepner, H. S. | Bloomington | Monroe |
| *Herbst, R. R. | Hammond | Lake |
| Herd, Cloyn R. | Peru | Miami |
| *Herendeen, E. V. | Rochester | Fulton |
| *Heritier, Jules | Columbia City | Whitley |
| Herr, John W. | Mount Vernon | Posey |
| *Herrick, C. L. | Akron | Fulton |
| Herring, G. N. | Pierceton | Kosciusko |
| *Herrold, G. W. | La Fayette | Tippecanoe |
| Hershey, E. A. | Churubusco | Whitley |
| Hervey, Samuel W. (H) | Fortville | Hancock |
| Herzer, C. C. | Evansville | Vanderburgh |
| Hetherington, A. M. | Indianapolis | Marion |
| *Hetherington, John A. | Indianapolis | Marion |
| Heubi, John E. | Indianapolis | Marion |
| Hewins, Warren W. | Evansville | Vanderburgh |
| Hewitt, John H. | Indianapolis | Fountain-Warren |
| *Hewitt, M. I. | South Bend | St. Joseph |
| *Hewlett, Thomas H. | New Albany | Floyd |
| *Hiatt, R. L. | Richmond | Wayne-Union |
| *Hibner, Nolan A. | Indianapolis | Marion |
| *Hickman, W. R. | Logansport | Cass |
| Hickman, Walter | Indianapolis | Marion |
| Hicks, H. S. | Hammond | Lake |
| Hicks, James M. | Huntington | Huntington |
| Hiestand, H. B. | Pennville | Jay |
| Hiestand, H. J. | Pennville | Jay |
| Higbee, Paul | Sullivan | Sullivan |
| Higgins, O. C. | Lebanon | Boone |
| Hilbert, John W. | South Bend | St. Joseph |
| Hildebrand, W. O. | Topeka | Lagrange |
| Hill, H. D. | Richmond | Wayne-Union |
| *Hill, H. E. | Muncie | Delaware-Blackford |
| *Hill, Paul G. | Cambridge City | Wayne-Union |
| *Hill, Robert | Muncie | Delaware-Blackford |
| *Hilldrup, Don G. | Indianapolis | Marion |
| Hillery, J. L. | Silver Lake | Kosciusko |
| Hillis, L. J. | Logansport | Cass |
| *Hillman, Marion W. | South Bend | St. Joseph |
| Hillman, W. H. | South Bend | St. Joseph |
| *Himebaugh, Gilbert | Indianapolis | Marion |
| Himler, James M. | Indianapolis | Marion |
| Hinchman, C. P. | Geneva | Adams |
| Hinchman, Jean F. | Muncie | Delaware-Blackford |
| Hinc, Ulis B. | Indianapolis | Marion |
| Hines, A. V. | Auburn | De Kalb |
| Hines, D. M. | Auburn | De Kalb |
| Hines, Don C. | Indianapolis | Marion |
| Hinkson, George D. | Gary | Lake |
| Hippensteel, R. R. | Indianapolis | Marion |
| *Hippensteele, R. O. | Fremont | Steuben |
| Hisrich, L. W. | Batesville | Ripley |
| Hochhalter, Marian | Logansport | Cass |
| Hodges, Fletcher | Indianapolis | Marion |
| Hodges, Wm. A. | Oaktown | Knox |
| *Hodgin, Philip | Rockville | Parke-Vermillion |
| Hodurski, Zigfield | Gary | Lake |
| Hoeger, H. R. | Brookville | Fayette-Franklin |
| Hoetzer, Ruth M. | Fort Wayne | Allen |
| Hofferkamp, A. G. | New Albany | Floyd |
| *Hoffman, A. F. | Fort Wayne | Allen |
| Hoffman, Curtis R. | Richmond | Wayne-Union |
| Hoffman, Doris | Vincennes | Knox |
| Hoffman, R. V. | South Bend | St. Joseph |
| Hofmann, Andrew | Hammond | Lake |
| Hofmann, J. Wm. | Indianapolis | Marion |
| Hofmann, S. P. | Fort Wayne | Allen |
| Holdeman, Lillian | South Bend | St. Joseph |
| Holderman, R. W. | South Bend | St. Joseph |
| Holladay, L. J. | La Fayette | Tippecanoe |
| *Holland, Chas. E. | Bloomington | Monroe |

| Name | City | County |
|---|---|---|
| Holland, E. E. | Richmond | Wayne-Union |
| Holland, D. J. | Bloomington | Monroe |
| *Holland, Philip | Bloomington | Monroe |
| Holliday, L. D. | Fairmont | Grant |
| Hollingsworth, A. A. | Indianapolis | Marion |
| Hollingsworth, Marshall P. (H) | Princeton | Gibson |
| *Hollingsworth, Maurice | Beech Grove | Marion |
| Holloway, W. A. | Logansport | Cass |
| Holman, J. E. | Indianapolis | Marion |
| *Holman, J. E. Jr. | Indianapolis | Marion |
| Holmes, Claude D. | Frankfort | Clinton |
| *Holmes, G. W. | Crown Point | Lake |
| Holmes, W. W. | Logansport | Cass |
| Holsinger, R. E. | Fort Wayne | Allen |
| Holtzendorf, C. E. (H) | St. Petersburg, Fla. | Marshall |
| Hooke, Sam W. | Noblesville | Hamilton |
| Hoopes, Jane | Evansville | Vanderburgh |
| Hoover, D. A. | Terre Haute | Vigo |
| Hoover, J. J. | Terre Haute | Vigo |
| *Hoover, Peter B. | Boonville | Warrick |
| Hopkins, Lester H. | Versailles | Ripley |
| *Hoppenrath, W. M. | Elwood | Madison |
| Hoppenrath, Wm. H. | Elwood | Madison |
| *Hord, L. J. | Shelbyville | Shelby |
| Hornaday, W. A. | Hammond | Lake |
| Horsman, Russell | Kokomo | Howard |
| Horswell, R. G. | Bristol | Elkhart |
| *Horton, Robert | Indianapolis | Marion |
| Hostetler, Carl M. | Goshen | Elkhart |
| House, J. W. | Bruceville | Knox |
| Houser, A. D. | Kingsbury | St. Joseph |
| Houser, Wayne W. | Monon | Tippecanoe |
| How, John T. | Lakeville | St. Joseph |
| How, Louis E. | Lakeville | St. Joseph |
| Howard, W. H. | Hammond | Lake |
| *Howell, R. D. | Indianapolis | Marion |
| Hoyt, Lester H. | Indianapolis | Marion |
| Huber, Carl P. | Indianapolis | Marion |
| Huckleberry, Carl D. | Danville | Marion |
| Huckleberry, Irvin | Salem | Washington |
| Hudson, Foster J. | Indianapolis | Marion |
| Huff, A. D. | Marion | Grant |
| Huffman, A. D. | South Bend | St. Joseph |
| Huffman, V. P. | South Whitley | Whitley |
| Huggins, Victor S. | Evansville | Vanderburgh |
| Hughes, J. E. | Indianapolis | Marion |
| Hughes, L. M. | Paragon | Morgan |
| Hughes, W. F. | Indianapolis | Marion |
| Hull, A. W. | Elkhart | Elkhart |
| Hull, King L. | Bloomfield | Greene |
| *Humphreys, John W. | Darlington | Montgomery |
| Hunn, M. F. | Elkhart | Elkhart |
| Hunt, Edgar J. | Terre Haute | Vigo |
| *Hunt, Gayle J. | Richmond | Wayne-Union |
| Hunt, George | Richmond | Wayne-Union |
| Hunt, Lee | Anderson | Madison |
| Hunt, W. B. (H) | Terre Haute | Vigo |
| Hunter, F. P. | La Fayette | Tippecanoe |
| Hunter, Lowell G. | Milan | Ripley |
| Huoni, J. S. | Jeffersonville | Clark |
| Hupe, Charles (H) | La Fayette | Tippecanoe |
| Hurley, Anson | Muncie | Delaware-Blackford |
| *Hurley, John R. | Daleville | Delaware-Blackford |
| Hurst, E. M. | Cloverdale | Putnam |
| *Hurt, L. B. | Indianapolis | Marion |
| Hurt, Paul T. | Indianapolis | Marion |
| Huse, William M. | Indianapolis | Marion |
| Husted, Robert | Hammond | Lake |
| Hutcheson, W. R. | Greencastle | Putnam |
| Hutchings, B. M. | Terre Haute | Vigo |
| Hutchinson, B. M. | Mishawaka | St. Joseph |
| *Hutto, W. H. | Kokomo | Howard |
| Hyde, Carroll | South Bend | St. Joseph |
| *Hyman, Bernard | Indianapolis | Marion |
| Hynes, Roy | Indianapolis | Marion |
| Hypes, Francis E. | Nappanee | Elkhart |
| Iddings, J. W. | Crown Point | Lake |
| Ikins, R. G. | La Fayette | Tippecanoe |
| Imhof, Joseph D. | Muncie | Delaware-Blackford |
| Ingalls, Clair | Washington | Daviess-Martin |
| Ingwell, Guy B. | Knox | LaPorte |
| Inlow, C. Fred | Shelbyville | Shelby |
| Inlow, Herbert | Shelbyville | Shelby |
| Inlow, W. D. | Shelbyville | Shelby |
| Irey, P. R. | Plymouth | Marshall |
| Irwin, Seth | Summitville | Madison |
| Ish, E. A. | Waterloo | De Kalb |
| *Iske, Paul G. | Indianapolis | Marion |
| *Isler, N. C. | Jeffersonville | Clark |
| *Iterman, G. E. | New Castle | Henry |
| Ives, R. J. | Francesville | Pulaski |
| *Jackman, Abraham I. | Hammond | Lake |
| Jackson, F. E. | Indianapolis | Marion |
| *Jackson, J. K. | Aurora | Dearborn-Ohio |
| Jackson, J. L. | Indianapolis | Marion |
| Jackson, J. M. | Aurora | Dearborn-Ohio |
| Jackson, J. W. | Indianapolis | Marion |
| Jacobs, H. A. | Indianapolis | Marion |
| *Jacobs, L. G. | Indianapolis | Marion |
| Jaeger, A. S. | Indianapolis | Marion |
| James, N. A. | Tell City | Perry |
| Jaquith, O. S. | Indianapolis | Marion |
| Jarrett, Paul E. | Anderson | Madison |
| *Jay, Arthur N. | Indianapolis | Marion |
| Jeffries, K. I. | Indianapolis | Marion |
| Jenkins, J. M. (H) | Cortland | Jackson |
| *Jenkinson, W. E. | Mount Vernon | Posey |
| Jennings, Frank | Indianapolis | Marion |
| Jermstad, Robert J. | Fort Wayne | Allen |
| Jerome, J. N. (H) | Evansville | Vanderburgh |
| Jewell, Earl B. | Logansport | Cass |
| Jewett, Robert E. | Indianapolis | Wabash |
| Jinks, C. H. | Indianapolis | Marion |
| Jinnings, Loren E. | Garrett | DeKalb |
| *Jobes, James E. | Indianapolis | Marion |
| Jobes, N. E. | Indianapolis | Marion |
| Joest, Charles O. | Mishawaka | St. Joseph |
| Johns, D. R. | East Chicago | Lake |
| Johnson, C. E. | Rensselaer | Jasper-Newton |
| Johnson, E. N. | Sandborn | Knox |
| Johnson, Earl E. | Covington | Fountain-Warren |
| Johnson, F. D. | Waynetown | Montgomery |
| Johnson, G. C. | Evansville | Vanderburgh |
| Johnson, J. J. | Milltown | Crawford |
| Johnson, M. H. C. | Vincennes | Knox |
| Johnson, Paul S. | Richmond | Wayne-Union |
| *Johnson, R. B. | Butlerville | Jennings |
| *Johnson, S. L. | Evansville | Vanderburgh |
| Johnson, Thomas W. | Indianapolis | Marion |
| Johnson, W. A. | Perrysville | Parke-Vermillion |
| Johnson, Wm. F. | Indianapolis | Marion |
| *Johnston, D. D. | Fort Wayne | Allen |
| Johnston, R. G. | Huntington | Huntington |
| Jolly, W. P. | Richland | Spencer |
| Jones, Albert T. | Pendleton | Madison |
| Jones, Clifford M. | Whiting | Lake |
| Jones, D. D. | Berne | Adams |
| Jones, David E. | Indianapolis | Marion |
| Jones, E. S. | Hammond | Lake |
| *Jones, Francis P. | Indianapolis | Marion |
| Jones, George | Wanamaker | Marion |
| Jones, H. E. | Anderson | Madison |
| Jones, Paul A. | Lyons | Greene |
| Jones, R. B. | La Porte | La Porte |
| Jones, Rilus E. | Clayton | Hendricks |
| Jones, W. Duane | Indianapolis | Marion |
| Jones, W. W. | Frankfort | Clinton |
| Jordan, Cecil | Denver | Miami |
| *Jordan, Leo E. | Lynn | Randolph |
| Jordan, Minnetta Flinn | Wabash | Wabash |
| Josif, Lazar | East Chicago | Lake |
| Kahan, H. L. | Gary | Lake |
| *Kahler, M. V. | Indianapolis | Marion |
| *Kalb, Everett L. | Indianapolis | Marion |
| Kayler, James | Plymouth | Marshall |
| Kamm, Bernard A. | South Bend | St. Joseph |
| Kamman, G. H. | Seymour | Jackson |
| Kamman, H. H. | Columbus | Bartholomew |
| *Kammen, Leo | Indianapolis | Marion |
| Kammer, Adolph G. | East Chicago | Lake |
| Kantzer, Floyd B. | Garrett | DeKalb |
| Karsell, W. A. | Bloomington | Monroe |
| Katterjohn, James C. | Indianapolis | Marion |
| Kauffman, H. M. | Evansville | Vanderburgh |
| Kauffman, Sidney A. | Indianapolis | Marion |
| Kay, Oran | Spencer | Owen |
| *Keefe, Thomas L. | Logansport | Cass |
| Keeling, F. E. | Portland | Jay |
| Keeling, J. E. (H) | Waldron | Shelby |
| Keenan, R. L. | Indianapolis | Marion |
| Keever, C. H. | Indianapolis | Marion |
| Keiser, V. D. | Indianapolis | Marion |
| Keith, F. E. | Richmond | Wayne-Union |
| Keller, F. G. (H) | Alexandria | Madison |
| *Kelly, Don E. | Indianapolis | Marion |
| Kelly, F. H. | Argos | Marshall |
| Kelly, J. F. | Indianapolis | Marion |
| Kelly, J. N. | La Porte | La Porte |
| *Kelly, W. C. | Indianapolis | Marion |
| Kelly, W. R. | Goshen | Elkhart |
| Kelly, Walter F. | Indianapolis | Marion |
| Kelsey, L. E. | Kewanna | Fulton |
| Kelsey, Robert M. | La Porte | La Porte |
| Kemp, John T. | Michigan City | La Porte |
| Kemp, W. A. | Connersville | Fayette-Franklin |
| Kemper, A. T. | Muncie | Delaware-Blackford |
| Kempf, G. F. | Indianapolis | Marion |
| *Kendall, F. M. | Alexandria | Madison |
| *Kendrick, Frank J. | Gary | Lake |
| *Kendrick, W. M. | Indianapolis | Marion |
| Kennedy, Eva | Camden | Carroll |
| *Kennedy, H. F. | Indianapolis | Marion |
| Kennedy, R. O. | Rushville | Rush |
| Kennedy, Samuel (H) | Shelbyville | Shelby |
| Kennedy, W. U. | New Castle | Henry |
| Kennington, D. J. | Michigan City | La Porte |
| Kent, J. A. | Mulberry | Clinton |
| Kenyon, C. E. | Cambridge City | Wayne-Union |
| Kepler, R. W. | La Porte | La Porte |
| Kercheval, C. F. | Clinton | Parke-Vermillion |
| Kercheval, J. M. | Clinton | Parke-Vermillion |
| Kern, C. B. | Muncie | Delaware-Blackford |
| *Kern, C. G. | Lebanon | Boone |
| Kerr, A. R. | Attica | Fountain-Warren |
| Kerr, Harry R. | Indianapolis | Marion |
| Kerrigan, J. J. (H) | Michigan City | La Porte |
| Kerrigan, R. L. | Michigan City | LaPorte |
| Keserie, N. E. | Gary | Lake |
| Ketcham, Jane M. | Indianapolis | Marion |
| Ketcham, John S. | Rossville | Clinton |
| Kidd, James G. | Roann | Wabash |
| Kidder, J. J. | Salamonia | Jay |
| *Kidder, Orva T. | Fort Wayne | Allen |
| *Kilgore, Byron | Danville | Hendricks |
| Kilgore, F. T. | Yorktown | Delaware-Blackford |
| Killough, Aimee R. | Michigan City | La Porte |
| *Kilmer, John H. | Fort Wayne | Allen |
| Kim, Young D. | Beech Grove | Marion |
| Kimball, Glen D. | Marion | Grant |
| Kime, Charles E. | Indianapolis | Marion |
| Kime, E. N. | Bloomington | Marion |
| Kime, J. T. (H) | Petersburg | Pike |
| *Kimmich, John M. | Kokomo | Howard |
| Kindell, H. D. | New Richmond | Montgomery |
| King, B. A. | Anderson | Madison |
| King, Jack | Vevay | Switzerland |
| *King, Joseph W. | Anderson | Madison |
| King, M. O. | Rochester | Fulton |
| King, P. C. | Swayzee | Grant |
| King, Wm. E. | Indianapolis | Marion |
| Kingsbury, J. K. | Indianapolis | Marion |
| Kinnaman, H. A. | Crawfordsville | Montgomery |
| *Kinneman, R. E. | Greenfield | Hancock |
| Kinsey, Joseph H. | Richmond | Wayne-Union |
| *Kirch, L. N. | Indianapolis | Marion |
| Kirkpatrick, A. M. (H) | Columbus | Bartholomew |
| *Kirshman, F. E. | Muncie | Delaware-Blackford |
| Kirtley, J. M. | Crawfordsville | Montgomery |

| Name | City | County |
|---|---|---|
| Kiser, E. F. | Indianapolis | Marion |
| *Kissinger, K. L. | Angola | Steuben |
| *Kistler, James J. | La Porte | La Porte |
| Kistner, Arthur W. | Elkhart | Elkhart |
| Kistner, John W. | Elkhart | Elkhart |
| *Kitterman, Harry E. | Indianapolis | Marion |
| Klahr, Elsworth | South Bend | St. Joseph |
| *Klain, B. V. | Indianapolis | Marion |
| Klein, Else | South Bend | St. Joseph |
| Klein, H. P. | Fort Branch | Gibson |
| Kleindorfer, R. L. | Evansville | Vanderburgh |
| Kleinman, F. J. | Hebron | Porter |
| Kleplnger, H. E. | La Fayette | Tippecanoe |
| Klinger, Maurice O. | Plymouth | Marshall |
| Knapp, A. B. (H) | Vincennes | Knox |
| Knapp, Arthur L. | South Bend | St. Joseph |
| Knepple, L. R. | Kokomo | Howard |
| Knode, Kenneth T. | South Bend | St. Joseph |
| Knoefel, Peter | Louisville, Ky. | Vigo |
| Knott, Harry | Plymouth | Marshall |
| *Knoy, Norris J. | Gary | Lake |
| *Kobrak, H. F. | Gary | Lake |
| *Kobrin, M. W. | Gary | Lake |
| Koehler, Elmer G. | Elkhart | Elkhart |
| Kohlstaedt, George | Indianapolis | Marion |
| Kohlstaedt, K. G. | Indianapolis | Marion |
| Kohne, G. J. | Decatur | Adams |
| Kolettis, George J. | Gary | Lake |
| Komoroske, J. E. | East Chicago | Lake |
| Koons, Karl M. | Indianapolis | Marion |
| *Kopcha, Joseph E. | Whiting | Lake |
| Kopp, Herschel S. | Indianapolis | Marion |
| Kopp, O. A. | Anderson | Madison |
| *Korn, Jerome M. | Gary | Marion |
| Kornafel, L. H. | Indianapolis | Marion |
| *Kraft, Bennett | Indianapolis | Marion |
| Kraft, Haldon C. | Noblesville | Allen |
| Kraft, R. W. | Hobart | Lake |
| Kramer, A. A. | South Bend | St. Joseph |
| Kraning, Kenneth | Kewanna | Fulton |
| Kratzer E. F. | Kokomo | Miami |
| *Kreible, Wm. Wymond | Clay City | Clay |
| Kremer, N. A. | Madison | Jefferson |
| *Kress, George L. | Warsaw | Kosciusko |
| *Kressler, Leon | Rensselaer | Jasper-Newton |
| Kretsch, R. W. | Hammond | Lake |
| Krieger, George M. | Michigan City | La Porte |
| Krueger, Frederick W. | Richmond | Wayne-Union |
| Kruse, E. H. | Fort Wayne | Allen |
| Kruse, Walter E. | Fort Wayne | Allen |
| Kubik, Francis J. | Westville | La Porte |
| *Kudele, L. T. | Whiting | Lake |
| Kuhn, Hedwig S. | Hammond | Lake |
| Kuhn, Hugh A. | Hammond | Lake |
| *Kuhn, R. W. | Wilkinson | Hancock |
| Kunkler, Joseph | Terre Haute | Vigo |
| Kunkler, Wm. C. | Terre Haute | Vigo |
| Kuntz, Herman W. | Indianapolis | Marion |
| Kurtz, Fred B. | Indianapolis | Marion |
| Kurtz, Philip L. | Indianapolis | Marion |
| Kurtz, William A. | Tipton | Tipton |
| *Kwitny, I. J. | Indianapolis | Marion |
| *LaBier, C. Russell | Terre Haute | Vigo |
| LaBier, Clarence R. | Terre Haute | Vigo |
| LaBonte, Napoleon | Indianapolis | Marion |
| *Ladig, Donald S. | Fort Wayne | Allen |
| *LaDine, C. B. | Indianapolis | Marion |
| LaDuron, Jules | Muncie | Delaware-Blackford |
| *LaFata, F. Paul | Gary | Lake |
| *LaFollette, Forrest | | Harrison |
| Laird, L. A. | North Webster | Kosciusko |
| Lake, G. H. | Pleasant Lake | Steuben |
| Lamb, E. B. | Indianapolis | Marion |
| Lamb, Russell | Indianapolis | Marion |
| *Lamber, C. K. | Indianapolis | Marion |
| Lambert, J. L. (H) | Brazil | Clay |
| Lambright, Simeon (H) | Danville, Ill. | Fountain-Warren |
| *Lamey, James L. | Anderson | Madison |
| *Lamey, P. T. | Anderson | Madison |
| Lane, W. H. (H) | Angola | Steuben |
| *Lane, Wm. H. | South Bend | St. Joseph |
| *Lang, Joseph E. | South Bend | St. Joseph |
| Lang, Shirley C. | Evansville | Vanderburgh |
| Langdon, H. K. | Indianapolis | Marion |
| *Langenbahn, C. J. | South Bend | St. Joseph |
| Langsdon, Fred | Gaston | Delaware-Blackford |
| *Lansford, John | Redkey | Jay |
| Lapenta, V. A. | Indianapolis | Marion |
| *Lapid, G. G. | East Chicago | Lake |
| Larkin, Bernard J. | Indianapolis | Marion |
| *Larmore, J. L. | Muncie | Delaware-Blackford |
| Larrabee, W. H. | New Palestine | Hancock |
| Larrison, G. D. | Morocco | Jasper-Newton |
| Larson, G. O. | La Porte | La Porte |
| *LaSalle, R. M. | Wabash | Wabash |
| *Laubscher, Clarence | Evansville | Vanderburgh |
| Laudeman, W. A. | Elwood | Madison |
| Lauer, A. J. | Whiting | Lake |
| Lauer, D. B. | Dana | Parke-Vermillion |
| Laval, Wm. (H) | Evansville | Vanderburgh |
| Lavengood, R. W. | Marion | Grant |
| Lawler, George F. | Indianapolis | Marion |
| *Lawrence, Joseph C. | Evansville | Vanderburgh |
| Laws, H. J. | La Fayette | Tippecanoe |
| Laws, Kenneth F. | La Fayette | Tippecanoe |
| Lawson, I. H. | Kendallville | Noble |
| Lawson, W. T. (H) | Danville | Hendricks |
| Lazo, V. R. | Wheatland | Knox |
| Leasure, J. K. | Indianapolis | Marion |
| Leatherman, C. A. | Muncie | Delaware-Blackford |
| Leatherman, H. L. | Indianapolis | Marion |
| LeClaire, Henri | Martinsville | Morgan |
| Lee, A. H. | Terre Haute | Vigo |
| *Lee, Glen Ward | Richmond | Wayne-Union |
| Lee, John M. | Dayton, Ohio | Rush |
| Leff, Abe | Indianapolis | Marion |
| *Leffel, James M. | Indianapolis | Marion |
| *Lehmberg, O. F. | Columbia City | Whitley |
| Leich, Charles F. | Evansville | Vanderburgh |
| Leiter, Arthur | Columbia City | Whitley |
| Lemmon, B. E. | Indianapolis | Marion |
| Lemon, Herbert K. | Goshen | Elkhart |
| *Lenk, George G. | Fort Wayne | Allen |
| Leonard, Henry S. | Indianapolis | Marion |
| *Leser, R. U. | Indianapolis | Marion |
| *Leslie, Ermil | Evansville | Vanderburgh |
| Lett, Emory B. | Loogootee | Daviess-Martin |
| Levering, Guy P. | La Fayette | Tippecanoe |
| Levi, Leon | Indianapolis | Marion |
| Levin, Eli | East Chicago | Lake |
| Lewis, J. R. | Indianapolis | Marion |
| *Lewis, James F. | Liberty | Wayne-Union |
| Lewis, Robert J. | Lawrence | Marion |
| *Libbert, E. L. | Lawrenceburg | Dearborn-Ohio |
| *Libnoch, Casimir | South Bend | St. Joseph |
| *Lichtenberg, Melvin | Indianapolis | Marion |
| Lieberman, Arnold L. | Tuscon, Ariz. | Lake |
| Life, Homer | New Castle | Henry |
| Lindenmuth, E. Oscar | Indianapolis | Marion |
| Lindquist, N. S. | South Bend | St. Joseph |
| *Lindsay, H. B. | Washington | Daviess-Martin |
| Line, H. E. | Chili | Miami |
| Lingeman, Byron N. | Crawfordsville | Montgomery |
| Lingeman, E. L. | Indianapolis | Marion |
| Link, Goethe | Indianapolis | Marion |
| Linn, E. E. | La Porte | La Porte |
| Linton, C. D. | Walkerton | St. Joseph |
| Linton, C. E. | Medaryville | Pulaski |
| Liss, Emanuel C. | South Bend | St. Joseph |
| *List, Harold E. | Marion | Grant |
| Littell, J. J. | Indianapolis | Marion |
| Little, J. A. | Evanston, Ill. | Cass |
| Little, John W. | Indianapolis | Marion |
| *Little, John W., Jr. | Indianapolis | Marion |
| Little, W. D. | Indianapolis | Marion |
| Litzenberger, S. W. | Anderson | Madison |
| Lochry, R. L. | Indianapolis | Marion |
| *Loehr, W. M. | Indianapolis | Marion |
| *Loewenstein, W. L. | Terre Haute | Vigo |
| Logan, A. R. | Petersburg | Pike |
| Logan, F. W. | Mishawaka | St. Joseph |
| *Logan, Jesse R. | Evansville | Vanderburgh |
| Lohman, Maurice | Fort Wayne | Allen |
| *Lohman, Robert M. | Indianapolis | Allen |
| Lomax, Claude C. | Indianapolis | Marion |
| Long, J. A. (H) | Anderson | Madison |
| *Long, Leonard | Bluffton | Wells |
| *Long, Paul L. | Anderson | Madison |
| Long, W. H. | Indianapolis | Marion |
| Loomis, DeWitt | Boonville | Warrick |
| Loomis, J. F. (H) | St. Petersburg, Fla. | Grant |
| Loomis, N. S. | Indianapolis | Marion |
| Loop, Floyd A. | La Fayette | Tippecanoe |
| Loop, Frederick A. | La Fayette | Tippecanoe |
| Lord, G. C. | Indianapolis | Marion |
| Lorenty, T. B. | Gary | Lake |
| *Loring, Mark L. | Valparaiso | Porter |
| *Loudermilk, J. L. | Indianapolis | Marion |
| *Love, George N. | Connersville | Fayette-Franklin |
| Love, John R. | Terre Haute | Vigo |
| Lovell, Martin H. | Gary | Lake |
| *Lovett, H. D. | Indianapolis | Marion |
| Loving, J. B. | New Goshen | Vigo |
| *Luckett, C. L. | Boonville | Warrick |
| Luckett, Coen L. | Terre Haute | Vigo |
| Luckey, H. A. | Wolf Lake | Noble |
| Luckey, R. C. | Wolf Lake | Noble |
| Ludwig, Oscar D. | Indianapolis | Marion |
| Lukemeyer, E. G. (H) | Huntingburg | Dubois |
| Lukemeyer, L. C. (H) | Huntingburg | Dubois |
| Lukemeyer, St. John | Jasper | Dubois |
| Lukenbill, Emery D. | Indianapolis | Marion |
| *Lund, L. C. | Argos | Marshall |
| *Lundt, Milo O. | Elkhart | Elkhart |
| Lung, B. D. | Kokomo | Howard |
| Lutes, D. L. | Dublin | Wayne-Union |
| Lutz, Georgianna | Gary | Lake |
| Luzadder, J. E. | Bloomington | Monroe |
| Luzadder, J. E., Jr. | New Carlisle | St. Joseph |
| Lybrook, D. E. | Young America | Cass |
| Lynch, Harold D. | Evansville | Vanderburgh |
| Lynch, Otho R. | Peru | Tippecanoe |
| *Lynch, O. R. | Marengo | Crawford |
| Lynch, Paul | Evansville | Vanderburgh |
| Lynn, F. M. (H) | Peru | Miami |
| Lyon, Florence | Portland | Jay |
| Lyons, Charles | Parker | Delaware-Blackford |
| Lyons, R. E., Jr. | Bloomington | Monroe |
| MacBeth, Albert H. (H) | Fort Wayne | Allen |
| MacDonald, J. A. | Indianapolis | Marion |
| Mace, E. E. | New Palestine | Hancock |
| Macer, Clarence G. | Evansville | Vanderburgh |
| Mac Gregor, D. E. | Indianapolis | Marion |
| *Machlan, H. F. | Indianapolis | Marion |
| Machledt, J. H. | Whiteland | Johnson |
| *MacKenzie, Pierce | Evansville | Vanderburgh |
| Mackey, C. G. | Culver | Marshall |
| Mackey, Harry S. | Indianapolis | Marion |
| *Macy, George | Columbus | Bartholomew |
| Magennis, H. L. | Indianapolis | Marion |
| *Mahoney, Charles L. | Terre Haute | Vigo |
| Mahuron, Boyd L. | Greensburg | Decatur |
| Maierhofer, Elmer R. | Walkerton | La Porte |
| Majsterek, S. L. | Gary | Lake |
| Malcolm, Russell | Richmond | Wayne-Union |
| Malmstone, F. A. | Griffith | Lake |
| Malone, L. A. | Terre Haute | Vigo |
| *Malott, Fred | Converse | Miami |
| Malouf, S. D. | Peru | Miami |
| *Malstaff, C. M. | South Bend | St. Joseph |
| *Maly, C. H. | Indianapolis | Marion |
| Manion, Marlow W. | Indianapolis | Marion |
| *Manley, C. N. | Rising Sun | Dearborn-Ohio |
| Mann, Mortimer | Indianapolis | Marion |
| Manning, Joseph C. | Indianapolis | Marion |
| *Mansfield, Max R. | Indianapolis | Marion |
| Maple, J. B. | Sullivan | Sullivan |
| Marchand, Austin F. | Haubstadt | Gibson |

| Name | City | County |
|---|---|---|
| Marchand, Edwin V. | Haugstadt | Gibson |
| Marchant, C. H. | Bloomington | Monroe |
| Marcus, M. C. | Gary | Lake |
| *Maris, Lee J. | Attica | Fountain-Warren |
| Markel, I. J. | Elkhart | Elkhart |
| Markley, H. W. | Rochester | Fulton |
| *Marks, H. H. | Evansville | Vanderburgh |
| Marks, Ora L. | East Chicago | Lake |
| Marsh, Chester A. | Hagerstown | Henry |
| Marsh, George W. | Otterbein | Benton |
| Marsh, J. P. | Blountsville | Henry |
| *Marshall, A. L. | Indianapolis | Marion |
| Marshall, Augustus L. | Indianapolis | Marion |
| Marshall, B. W. | Nashville | Bartholomew |
| Marshall, C. R. | Indianapolis | Marion |
| Marshall, George | Bourbon | Marshall |
| Marshall, L. C. | Mount Summit | Henry |
| Marshall, T. J. | Charlestown | Clark |
| *Marshall, William P. | Indianapolis | Marion |
| Martin, C. E. | Lynn | Randolph |
| Martin, F. V. | Michigan City | La Porte |
| Martin, Frank D. | Bedford | Lawrence |
| Martin, Floyd S. | Goshen | Elkhart |
| Martin, Guy | Seymour | Jackson |
| Martin, Harold R. | Lafayette | Tippecanoe |
| Martin, Hugh E. | Indianapolis | Marion |
| Martin, H. G. | La Fayette | Tippecanoe |
| Martin, Joe M. | Lafayette | Tippecanoe |
| *Martin, L. H. | Indianapolis | Marion |
| Martin, W. B. | La Porte | La Porte |
| Martin, Will J. | Kokomo | Howard |
| Martz, Carl D. | Indianapolis | Marion |
| Mason, Bernard | South Bend | St. Joseph |
| Mason, Everett E. | Evansville | Vanderburgh |
| Mason, L. R. | Muncie | Delaware-Blackford |
| *Mast, Karl F. | Fort Wayne | Allen |
| *Masters, J. M. | Indianapolis | Marion |
| Masters, R. J. | Indianapolis | Marion |
| Mather, J. W. | East Gary | Lake |
| Mathews, W. C. | Kentland | Jasper-Newton |
| Mathys, Alfred | Mauckport | Harrison |
| *Matthew, J. R. | Knox | Starke |
| Matthew, W. B. | Indianapolis | Marion |
| Matthews, B. J. | Indianapolis | Marion |
| Mattbews, Chas. B. | Hammond | Lake |
| Matthews, D. W. | North Vernon | Jennings |
| *Mattox, Don M. | Terre Haute | Vigo |
| Maurer, J. F. | Brazil | Clay |
| Maurer, Robert M. | Brazil | Clay |
| Mavity, D. E. (H) | Fowler | Benton |
| Maxwell, J. B. (H) | Logansport | Cass |
| May, George A. | Madison | Jefferson |
| May, R. M. | Gary | Lake |
| Mayfield, C. H. | Reynolds | Tippecanoe |
| McArdle, Edward G. | Fort Wayne | Allen |
| *McBane, John | Fortville | Hancock |
| McBride, E. C. | Terre Haute | Vigo |
| McBride, James S. | Indianapolis | Marion |
| McBride, Noel S. | Terre Haute | Vigo |
| McCabe, J. E. | Otterbein | Benton |
| *McCabe, Theodore E. | Fort Wayne | Allen |
| McCallum, Joseph T. C. | Indianapolis | Marion |
| McCarthy, F. G. | Terre Haute | Vigo |
| McCarthy, Jeremiah A. | Whiting | Lake |
| *McCartney, Donald H. | Indianapolis | Marion |
| *McCarty, Virgil | Princeton | Gibson |
| McCaskey, C. H. | Indianapolis | Marion |
| McCaskey, G. H. | Winamac | Pulaski |
| McCay, O. L. | Romney | Tippecanoe |
| McClain, Marvin | Scottsburg | Scott |
| McClellan, John B. | Lafayette | Tippecanoe |
| McClelland, D. C. | La Fayette | Tippecanoe |
| McClintock, James A. | Muncie | Delaware-Blackford |
| McClure, S. E. | Monon | Tippecanoe |
| *McConnell, Wm. C. | Sunman | Ripley |
| McCool, J. H. | Evansville | Vanderburgh |
| McCool, W. E. (H) | Evansville | Vanderburgh |
| McCormick, C. O. | Indianapolis | Marion |
| McCormick, H. D. | Vincennes | Knox |
| *McCormick, W. C. | Terre Haute | Vigo |
| McCown, P. E. | Indianapolis | Marion |
| McCoy, George A. | Indianapolis | Putnam |
| McCoy, Roy R. | Fort Wayne | Allen |
| McCracken, J. O. | Montgomery | Daviess-Martin |
| McCraley, William J. | South Bend | St. Joseph |
| McCulloch, C. B. | Indianapolis | Marion |
| McCullough, J. Y. | New Albany | Floyd |
| McDaniel, F. P. | Atlanta | Hamilton |
| McDevitt, D. R. | Indianapolis | Marion |
| *McDonald, J. D. | Evansville | Vanderburgh |
| McDonald, R. M. | Mishawaka | St. Joseph |
| McDonald, V. G. | Anderson | Madison |
| *McDowell, George A. | Fort Wayne | Allen |
| McDowell, Walter | Evansville | Vanderburgh |
| McElroy, J. S. | New Castle | Henry |
| McElroy, R. S. | Princeton | Gibson |
| *McEwen, J. W. | Terre Haute | Vigo |
| *McFadden, James M. | Fort Wayne | Allen |
| *McFall, V. F. | Anderson | Madison |
| McFarland, Corley B. | South Bend | St. Joseph |
| McGaughey, W. M. | Greencastle | Putnam |
| McGuire, D. F. | East Chicago | Lake |
| McIlwain, Eleanor | Marion | Grant |
| McIlwain, Robert | Marion | Grant |
| McIndoo, R. E | Kokomo | Howard |
| McIntyre, Charles J. | Indianapolis | Marion |
| McIntyre, J. M. | Indianapolis | Marion |
| McKay, J. D. (H) | Marion | Grant |
| McKean, T. J. | Montpelier | Adams |
| McKee, C. E. (H) | Dublin | Wayne-Union |
| McKee, H. S. | Greensburg | Decatur |
| McKeeman, D. H. | Fort Wayne | Allen |
| McKeeman, L. S. | Fort Wayne | Allen |
| McKenna, H. J. | South Bend | St. Joseph |
| *McKinley, A. D. | Indianapolis | Marion |
| McKinley, Joseph | Lafayette | Tippecanoe |
| McKinney, D. H. | La Fayette | Tippecanoe |
| McKinney S. L. | Huntingburg | Dubois |
| McKittrick, Jack | Washington | Daviess-Martin |
| McKittrick, Wm. O. | Washington | Daviess-Martin |
| *McLaughlin, C. P. | Pendleton | Madison |
| *McLaughlin, James R. | Logansport | Cass |
| McMeel, J. E. | South Bend | St. Joseph |
| McMichael, F. J. | Gary | Lake |
| *McMichael, R. M. | Muncie | Delaware-Blackford |
| McMurtry, L. K. | Evansville | Vanderburgh |
| McNabb, G. B. | Carthage | Rush |
| *McNaughton, L. M. | Petersburg | Pike |
| McNaull, Charles (H) | Indianapolis | Marion |
| McNeely, M. J. | Dillsboro | Dearborn-Ohio |
| McPherson, S. L. (H) | Washington | Daviess-Martin |
| McQueen, William | Jamestown, N. C. | Marion |
| *McQuiston, R. J. | Indianapolis | Marion |
| McVey, C. A. | Hammond | Lake |
| McWilliams, W. B. | Liberty | Wayne-Union |
| Mead, C. H. | Bluffton | Wells |
| *Meade, W. W. | Bicknell | Knox |
| Medcalf, N. L. | Lamar | Spencer |
| *Mengenhardt, D. S. | Indianapolis | Marion |
| Mebl, Rudolph A. | Evansville | Vanderburgh |
| Meikle, Louise J. | W. Lafayette | Tippecanoe |
| Meiks, Lyman T. | Indianapolis | Marion |
| Meiner, J. A. | Kokomo | Howard |
| Meiser, Robert | Huntington | Huntington |
| Meister, Doris | Anderson | Madison |
| Melloh, A. F. | Indianapolis | Marion |
| Mendenhall, C. D. | Indianapolis | Marion |
| Mendenhall, Edgar | Fort Wayne | Allen |
| Mendenhall, W. E. | Indianapolis | Marion |
| Mentendick, M. H. | Indianapolis | Marion |
| Mendez, Carlos | Elkhart | Elkhart |
| Mercer, Samuel R. | Fort Wayne | Allen |
| Merchant, Raymond | Lake Village | Jasper-Newton |
| Meredith, E. J. | Richmond | Wayne-Union |
| Mericle, Earl | Indianapolis | Marion |
| *Merrell, B. M. | Brownstown | Jackson |
| Merrell, Paul | Indianapolis | Marion |
| Mertz, H. O. | Indianapolis | Marion |
| Mervis, F. H. | East Chicago | Lake |
| Messer, F. W. | Kendallville | Noble |
| Metcalf, George B. | Anderson | Madison |
| Metcalfe, G. E. | South Bend | St. Joseph |
| Meyer, Herman A. | Fort Wayne | Allen |
| Meyer, K. T. | Evansville | Vanderburgh |
| *Meyer, O. L. | Portland | Jay |
| Meyer, R. C. | Vincennes | Knox |
| *Michaelis, S. C. | Fort Wayne | Allen |
| Michaels, J. F. | Edinburg | Johnson |
| Micheli, A. J. | Indianapolis | Marion |
| Middleton, H. N. | Indianapolis | Madison |
| Mikesch, W. H. | South Bend | St. Joseph |
| Miley, W. M. | Anderson | Madison |
| Miller, Albert W. | Indianapolis | Marion |
| *Miller, Carl G. | Fort Wayne | Allen |
| Miller, Charles A. | Princeton | Gibson |
| Miller, D. B. | Terre Haute | Vigo |
| Miller, E. H. | Valparaiso | Porter |
| Miller, H. A. | Marion | Grant |
| Miller, H. L. | West Baden | Orange |
| Miller, Harold E. | Seymour | Jackson |
| *Miller, Henry P. | Fort Wayne | Allen |
| *Miller, Jack B. | Petersburg | Pike |
| Miller, J. Don | Indianapolis | Marion |
| Miller, L. B. | Evansville | Vanderburgh |
| Miller, L. R. | Winslow | Pike |
| Miller, M. E. | Goshen | Elkhart |
| Miller, Mahlon F. | Fort Wayne | Allen |
| Miller, Milton | Evansville | Vanderburgh |
| Miller, Milo | South Bend | St. Joseph |
| Miller, Minor | Evansville | Vanderburgh |
| *Miller, Orval J. | Fort Wayne | Allen |
| Miller, Raymond D. | Indianapolis | Marion |
| Miller, R. S. | Indianapolis | Marion |
| *Miller, Richard C. | Indianapolis | Marion |
| *Miller, Richard H. | Fort Wayne | Allen |
| *Miller, Robert J. | Evansville | Vanderburgh |
| Miller, S. J. | West Lafayette | Tippecanoe |
| Miller, S. T. | Elkhart | Elkhart |
| Miller, Virgil | Akron | Fulton |
| Miller, Wm. A. | Hagerstown | Henry |
| *Miller, Wm. E. | South Bend | St. Joseph |
| Miller, Wm. T. | Indianapolis | Marion |
| *Millis, Robert | Crawfordsville | Montgomery |
| *Mills, J. F. | New Castle | Henry |
| Minczewski, Richard C. | Gary | Lake |
| Mino, Victor H. | Evansville | Vanderburgh |
| Mirro, John A. | Lowell | Lake |
| *Mishkin, Irving | Elkhart | Elkhart |
| Mitchell, Albert M. | Terre Haute | Vigo |
| Mitchell, E. T. | Romney | Tippecanoe |
| Mitchell, Earl H. | Indianapolis | Marion |
| Mitchell, G. L. | Smithville | Monroe |
| Mitchell, H. F. (H) | South Bend | St. Joseph |
| Mitchell, J. I. | Salem | Washington |
| Mitchell, R. E. | Indianapolis | Marion |
| Mitman, F. B. | Huntington | Huntington |
| Moats, C. F. | Fort Wayne | Allen |
| Moats, G. E. | Fort Wayne | Allen |
| Mobley, L. F. | Summitville | Madison |
| *Mock, E. L. | Bicknell | Knox |
| Modjeski, Raymond J. | Hammond | Lake |
| *Moehlenkamp, Chas. E. | Evansville | Vanderburgh |
| Moenning, W. P. | Indianapolis | Marion |
| Mohr, Anna Louise | Shelbyville | Shelby |
| Molloy, W. J. | Muncie | Delaware-Blackford |
| Molt, W. F. | Indianapolis | Marion |
| Montgomery, J. R. | Princeton | Gibson |
| Montgomery, L. G. | Muncie | Delaware-Blackford |
| Montgomery, S. B. | Cynthiana | Posey |
| Montgomery, Wm. F. | Indianapolis | Marion |
| Moore, B. B. | Indianapolis | Marion |
| *Moore, H. T. | Indianapolis | Marion |
| Moore, Martha | Butlerville | Jennings |
| Moore, Paul D. | Muncie | Delaware-Blackford |
| Moore, R. G. | Vincennes | Knox |
| Moore, Robert M. | Indianapolis | Marion |
| Moore, W. C. | Muncie | Delaware-Blackford |
| Moosey, Louis | Union Mills | La Porte |
| Moran, Mark M. | Portland | Jay |
| Moran, Noel D. | Versailles | Ripley |
| Moran, Richard J. | Rockville | Parke-Vermillion |
| *Moravec, Arthur E. | Fort Wayne | Allen |
| Morford, Guy | Muncie | Delaware-Blackford |

| Name | City | County |
|---|---|---|
| Morgan, Isabel | Ann Arbor, Michigan | Hendricks |
| Morgan, S. P. | La Porte | La Porte |
| Morr, J. W. | Albion | Noble |
| Morris, G. B. | Bluffton | Wells |
| *Morris, J. B. | Hammond | Lake |
| Morris, J. W. | Hartford City | Delaware-Blackford |
| *Morris, Marion H. | Indianapolis | Marion |
| Morris, W. F. | Fort Branch | Gibson |
| *Morris, Warren V. | Monticello | Tippecanoe |
| Morrison, C. C. | Greensburg | Decatur |
| *Morrison, D. A. | Kokomo | Howard |
| *Morrison, G. G. | Portland | Jay |
| Morrison, John S. (H) | Lafayette | Tippecanoe |
| Morrison, J. T. | Greensburg | Decatur |
| Morrison, Lindsey | Hammond | Lake |
| Morrison, Lewis E. II | Indianapolis | Marion |
| Morrison, W. R. | Kokomo | Howard |
| Morrow, R. D. | Connersville | Fayette-Franklin |
| Mortenson, L. J. | Fort Wayne | Allen |
| Morton, Walter P. | Indianapolis | Marion |
| Moser, E. B. | Windfall | Tipton |
| Moser, Edward | Woodburn | Allen |
| Moser, R. H. | Indianapolis | Marion |
| Moses, George E. | Worthington | Greene |
| *Moss, M. J. | Yorktown | Delaware-Blackford |
| Mothersill, M. H. | Indianapolis | Marion |
| Mott, C. A. | South Bend | St. Joseph |
| Moulton, Lillian | Indianapolis | Marion |
| *Mount, M. S. | Bloomfield | Greene |
| *Mount, Wm. | Crawfordsville | Montgomery |
| Mount, Wm. C. | Kirklin | Clinton |
| Mountain, Francis | Connersville | Fayette-Franklin |
| Moutoux, J. E. | Indianapolis | Marion |
| Mowrer, Giles E. | Jeffersonville | Clark |
| Mozingo, A. E. | Indianapolis | Marion |
| Muelchi, Adeline F. | Evansville | Vanderburgh |
| *Mueller, Lawrence | Fort Wayne | Allen |
| Mueller, Lillian B. | Indianapolis | Marion |
| *Muhleman, C. E. | La Porte | La Porte |
| *Mulcaby, B. J. | Muncie | Delaware-Blackford |
| Mull, P. L. | Pekin | Washington |
| *Muller, Lullus P. | Indianapolis | Marion |
| Mullikin, C. W. | Greensburg | Decatur |
| Mullikin, H. M. | Terre Haute | Vigo |
| Mullin, H. Y. | Rockfield | Carroll |
| Mumford, E. B. | Indianapolis | Marion |
| Muncie, H. L. | Brazil | Clay |
| Munk, C. E. | Kendallville | Noble |
| Murdock, H. L. | Fort Wayne | Allen |
| *Murphy, E. C. | South Bend | St. Joseph |
| Murphy, E. W. | Lanesville | Harrison |
| Murphy, Harry | Franklin | Johnson |
| Murphy, Josephine | South Bend | St. Joseph |
| Murphy, M. G. | Morgantown | Morgan |
| Murray, F. N. | Kokomo | Howard |
| Musselman, G. G. | Terre Haute | Vigo |
| Myers, B. D. | Bloomington | Monroe |
| Myers, Charles W. | Indianapolis | Marion |
| Myers, R. V. | Indianapolis | Marion |
| Myers, Wm. C. | Dana | Parke-Vermillion |
| Nafe, C. A. | Indianapolis | Marion |
| *Nahrwold, Elmer W. | Fort Wayne | Allen |
| Nance, W. K. | Vincennes | Knox |
| Napper, Floyd | Scottsburg | Scott |
| *Nash, Charles B. | Valparaiso | Porter |
| Nash, Justin R. | Albion | Noble |
| Nason, R. A. | Garrett | De Kalb |
| Naugle, R. A. | Wabash | Wabash |
| Nave, H. E. | Fountaintown | Shelby |
| Navin, Hugh K. | Fortville | Hancock |
| Nay, E. O. | Terre Haute | Vigo |
| *Need, Louis T. | Indianapolis | Marion |
| Neely, A. S. | Indianapolis | Marion |
| Nehil, L. W. | Indianapolis | Marion |
| *Neidballa, E. G. | Bristol | Elkhart |
| Neier, O. C. (H) | Indianapolis | Marion |
| Nelson, F. Dale | South Bend | St. Joseph |
| *Nelson, Paul Leon | Anderson | Madison |
| *Nelson, R. B. | Hammond | Lake |
| Nelson, Raymond | South Bend | St. Joseph |
| Nenneker, Henry | Evansville | Vanderburgh |
| Nesbit, L. L. | Anderson | Madison |
| Nesbit, O. B. | Gary | Lake |
| Netherton, C. R. | Chalmers | Tippecanoe |
| *Neumann, K. O. | La Fayette | Tippecanoe |
| Neuwalt, Frank | Gary | Lake |
| Newby, A. C. | Sheridan | Hamilton |
| Newcomb, John R. | Indianapolis | Marion |
| *Newcomb, Wm. K. | Royal Center | Cass |
| Newland, A. E. | Bedford | Lawrence |
| Newman, A. E. | Evansville | Vanderburgh |
| Niblack, E. S. | Terre Haute | Vigo |
| Niblack, J. S. | East Chicago | Lake |
| Nickel, Allen C. | Bluffton | Wells |
| *Nicosia, J. B. | East Chicago | Lake |
| Nie, Grover | Huntington | Huntington |
| *Nie, Louis W. | Huntington | Huntington |
| Niedermeyer, Alfred | Evansville | Vanderburgh |
| *Nigh, R. M. | Fairland | Shelby |
| *Nill, John H. | Fort Wayne | Allen |
| Nisenbaum, Harold | Evansville | Vanderburgh |
| Nixon, Byron | Farmland | Randolph |
| Nixon, J. E. | Portland | Jay |
| Noble, T. B. | Indianapolis | Marion |
| Noble, T. B., Jr. | Indianapolis | Marion |
| Noblitt, J. S. | Waveland | Montgomery |
| Nodinger, Louis | Hammond | Lake |
| Nolt, E. V. | Columbia City | Whitley |
| Nolting, H. F. | Indianapolis | Marion |
| Norman, O. B. | Indianapolis | Marion |
| *Norman, Wm. H. | Indianapolis | Marion |
| Norris, Allen A. | Elkhart | Elkhart |
| Norris, Ernest B. | Middlebury | Elkhart |
| Norris, H. L. | Indianapolis | Marion |
| Norris, Mary A. | Indianapolis | Marion |
| Norton, H. J. | Columbus | Bartholomew |
| *Norton, Horace | Indianapolis | Marion |
| Norton, Wm. J. (H) | Columbus | Bartholomew |
| Norwick, Sydney | Indianapolis | Marion |
| *Nourse, Myron H. | Indianapolis | Marion |
| Nugen, Harold | Auburn | De Kalb |
| *Nutter, W. H. | Rushville | Rush |
| Nyce, Holtz Wm. | Van Buren | Grant |
| Oak, D. D. | La Crosse | La Porte |
| O'Brien, Tracy | Danville | Putnam |
| Ochsner, Harold C. | Indianapolis | Marion |
| O'Connor, James J. | East Chicago | Lake |
| O'Dell, Harry | Farmersburg | Sullivan |
| O'Dell, Harry W. | Jersey City, N. J. | Sullivan |
| O'Dell, Thomas A. | Indianapolis | Marion |
| O'Hale, John A. | Richmond | Wayne-Union |
| *Olcott, C. W. | Aurora | Dearborn-Ohio |
| O'Leary, F. T. | Logansport | Cass |
| Oleck, Adrian | New Albany | Floyd |
| Oliphant, F. W. | Mount Vernon | Posey |
| Oliphant, J. T. | Farmersburg | Sullivan |
| *Oliphant, R. W. | Terre Haute | Vigo |
| Olson, K. L. | South Bend | St. Joseph |
| *Olvey, Otis N. | Noblesville | Hamilton |
| *Omstead, Milton H. | Petersburg | Pike |
| Oppenshaw, J. F. | Goodland | Tippecanoe |
| Oppenheimer, Ernst | Evansville | Vanderburgh |
| Orders, C. E. | Indianapolis | Marion |
| O'Rourke, Carroll | Fort Wayne | Allen |
| *Orr, W. Robert | Mishawaka | St. Joseph |
| Osborne, Harry S. | Indianapolis | Marion |
| Osterman, Louis | Seymour | Jackson |
| Ostrowski, L. J. | East Chicago | Lake |
| Ostrowski, R. O. | Hammond | Lake |
| *Oswalt, J. T. | Dunkirk | Jay |
| Otten, Claude F. | Indianapolis | Marion |
| Otten, Ralph E. | Darlington | Montgomery |
| Ottinger, R. C. | Indianapolis | Marion |
| Otto, Anthony E. (H) | Alexandria | Madison |
| Overman, F. V. | Tipton | Tipton |
| Overpeck, Charles | Greensburg | Decatur |
| Overpeck, George H. | Alexandria | Madison |
| Overshiner, Lyman | Columbus | Bartholomew |
| Owen, Abraham | Attica | Fountain-Warren |
| *Owen, J. E. | Indianapolis | Marion |
| Owen, Margaret T. | Bloomington | Monroe |
| Owens, Thomas R. | Muncie | Delaware-Blackford |
| Owsley, Charlotte | Hartford City | Delaware-Blackford |
| *Owsley, Guy A. | Hartford City | Delaware-Blackford |
| *Owsley, Robert | Hartford City | Delaware-Blackford |
| Oyer, J. H. | Fort Wayne | Allen |
| Pace, J. V. | New Albany | Floyd |
| Padgett, E. E. | Indianapolis | Marion |
| *Paff, W. A. | Elkhart | Elkhart |
| Pahmeier, J. W. | Sandborn | Knox |
| Painter, L. W. | Winchester | Randolph |
| *Paletz, Benjamin | Michigan City | La Porte |
| Palm, John M. | Brazil | Clay |
| Palmer, Russell H. | Gary | Lake |
| Palmer, Earl | Logansport | Cass |
| Panares, Solomon V. | Hammond | Lake |
| *Pancost, Vernon K. | Elkhart | Elkhart |
| *Pandolfo, Harry | Indianapolis | Marion |
| Paris, D. W. | Kokomo | Howard |
| Parker, Carl B. | Wingate | Montgomery |
| Parker, C. B. | Fort Wayne | Allen |
| *Parker, Earl E. | South Bend | St. Joseph |
| Parker, E. E. | Oxford | Benton |
| Parker, G. F. | Greencastle | Putnam |
| Parker, H. C. | Gary | Lake |
| Parker, H. E. | Lafayette | Tippecanoe |
| Parker, H. P. | Urbana | Wabash |
| Parker, J. F. | Indianapolis | Marion |
| Parker, Portia | Indianapolis | Marion |
| Parrish, Richard K. | Decatur | Adams |
| Patrick, G. B. | Elkhart | Elkhart |
| Patterson, William K. | Indianapolis | Marion |
| Patten, V. C. | Morristown | Shelby |
| Patton, Martin T. | Indianapolis | Marion |
| *Paulissen, George T. | Indianapolis | Marion |
| Pauszek, Thomas B. | South Bend | St. Joseph |
| Payne, A. C. | East Chicago | Lake |
| Paynter, L. W. | Salem | Washington |
| Paynter, Morris B. | Southport | Marion |
| *Peacock, Robert | Indianapolis | Marion |
| *Peacock, Norman F. | Crawfordsville | Montgomery |
| Pearce, Roy V. | Indianapolis | Marion |
| Pearlman, Samuel | La Fayette | Tippecanoe |
| Pearson, John R. | Bedford | Lawrence |
| Pearson, Lyman R. | Indianapolis | Marion |
| Pearson, Wm. E. | Wabash | Wabash |
| Pebworth, A. C. | Indianapolis | Marion |
| *Pebworth, J. T. | Indianapolis | Marion |
| Peck, Franklin B. | Indianapolis | Marion |
| Pectol, Charles F. | Spencer | Owen |
| Peirce, James D. | Indianapolis | Marion |
| *Pekarek, Edward A. | Whiting | Lake |
| Pell, H. M. | Brazil | Clay |
| *Pence, Benjamin F. | Columbia City | Whitley |
| Pennington, L. E. | Madison | Jefferson |
| Pennington, V. M. | Madison | Jefferson |
| Pennington, W. E. | Indianapolis | Marion |
| *Pentecost, Paul S. | Richmond | Wayne-Union |
| Permer, Erwin | Indianapolis | Marion |
| Perrin, K. F. | Fort Wayne | Allen |
| *Perry, F. G. | Plymouth | Marshall |
| Peters, R. J. D. | Indianapolis | Marion |
| Peterson, Joel A. | Lafayette | Tippecanoe |
| *Petitjean, H. G. | Haubstadt | Gibson |
| Petranoff, T. V. | Indianapolis | Marion |
| Petrass, Andrew | South Bend | St. Joseph |
| Petronella, S. J. | East Chicago | Lake |
| Pettibone, C. R. | Crown Point | Lake |
| Pettijohn, F. L. | Indianapolis | Marion |
| Peyton, Frank W. | La Fayette | Tippecanoe |
| *Pfaff, Dudley | Indianapolis | Marion |
| Pfaff, John A. | Indianapolis | Marion |
| Pfafflin, C. A. | Indianapolis | Marion |
| *Pfeifer, James M. | Lawrenceburg | Dearborn-Ohio |
| *Phillips, J. R. | Michigan City | La Porte |
| Phillips, W. R. | Glenwood | Fayette-Franklin |
| Phipps, D. L. (H) | Union City | Johnson |
| Phipps, Leland K. | Union City | Randolph |
| Plazza, Leonard F. | Michigan City | La Porte |
| *Picha, V. J. | Muncie | Delaware-Blackford |
| *Pickard, H. M. | Elkhart | Elkhart |
| Pierce, H. J. | Terre Haute | Vigo |
| Pierson, P. R. | New Albany | Floyd |
| Pierson, Robert H. | Spencer | Owen |

| Name | City | County |
|---|---|---|
| Pierson, Thomas A. | New Palestine | Hancock |
| *Pilcher, Jack | Indianapolis | Marion |
| *Pilot, Jean | Chicago, Ill. | Lake |
| Piper, Mark | New Castle | Henry |
| Pippenger, W. G. | Brook | Jasper-Newton |
| Pirkle, H. B. | Rockville | Parke-Vermillion |
| Pitkin, Edward M. | Martinsville | Morgan |
| Pitkin, M. C. | Martinsville | Morgan |
| *Plain, George | South Bend | St. Joseph |
| Ploughe, Monroe L. (H) | Elwood | Madison |
| Ploughe, R. R. | Elwood | Madison |
| *Poland, M. F. | Bloomington | Monroe |
| Polhemus, Gretchen I. | New Albany | Floyd |
| Pollard, Walter | Evansville | Vanderburgh |
| Pollock, E. L. | Vincennes | Knox |
| Pollom, Robert R. | Crawfordsville | Montgomery |
| Pontius, Minerva B. | Ann Arbor, Michigan | Vanderburgh |
| *Popp, M. F. | Fort Wayne | Allen |
| *Porter, Carl M. | Jasonville | Greene |
| Porter, E. A. | Westport | Decatur |
| Porter, George C. | Linton | Greene |
| Porter, G. S. | Williamsport | Fountain-Warren |
| Porter, John R. | Lebanon | Boone |
| Porter, Mac Guyer (H) | Elnora | Daviess-Martin |
| Porter, M. F. | Fort Wayne | Allen |
| *Porter, W. L. | College Corner, Ohio | Wayne-Union |
| Portteus, Walter L. | Franklin | Johnson |
| Possolt, T. R. | Plymouth | Marshall |
| Poston, C. L. | Richmond | Wayne-Union |
| Powell, E. H. | Valparaiso | Porter |
| Powell, J. Paxton | Indianapolis | Marion |
| Powell, Nettie B. (H) | Marion | Grant |
| Prather, S. A. | Vincennes | Knox |
| *Premuda, F. E. | East Chicago | Lake |
| Prenatt, Francis | North Madison | Jefferson |
| Prentiss, Nelson H. | Fort Wayne | Allen |
| *Present, Julian | Evansville | Vanderburgh |
| *Price, Douglas | Nappanee | Elkhart |
| Price, Melvin D. | Nappanee | Elkhart |
| Price, Sidney | Marion | Grant |
| Price, W. A. (H) | Nappanee | Elkhart |
| *Prough, W. A. | Indianapolis | Marion |
| Province, O. A. | Franklin | Johnson |
| Pryor, David G. | Jeffersonville | Clark |
| Pryor, R. C. | Indianapolis | Marion |
| Przednowek, A. C. | La Porte | La Porte |
| *Pugh, Willis L. | Evansville | Vanderburgh |
| Pulskamp, B. H. | Wolcottville | Noble |
| Puryear, J. O. | Gary | Lake |
| Puterbaugh, K. E. | Albany | Delaware-Blackford |
| *Pyle, Harold D. | South Bend | St. Joseph |
| *Quick, Wm. J. | Muncie | Delaware-Blackford |
| Quickel, Daniel L. (H) | Anderson | Madison |
| Quigley, Joseph B. | Indianapolis | Marion |
| Rabb, Harry | Indianapolis | Marion |
| Rabson, S. Milton | Fort Wayne | Allen |
| *Radivojevic, S. M. | Valparaiso | Porter |
| Ragsdale, H. C. | Bedford | Lawerence |
| Rainey, E. A. | Lebanon | Boone |
| Ralston, John D. | Indianapolis | Marion |
| Ramage, W. F. | Fortville | Hancock |
| Ramsay, J. P. (H) | Vincennes | Knox |
| *Ramsey, Frank B. | Indianapolis | Marion |
| Ramsey, H. S. | Bloomington | Monroe |
| *Randall, Karl C. II | La Fayette | Tippecanoe |
| Ranes, J. R. | Mount Vernon | Posey |
| Raney, B. B. | Linton | Greene |
| Rang, A. A. | Washington | Daviess-Martin |
| Ranke, John W. H. (H) | Fort Wayne | Allen |
| *Raphael, Isldor J. | Evansville | Vanderburgh |
| *Rarick, Alden J. | Cromwell | Noble |
| Rarlden, L. B. | Greenfield | Hancock |
| Rasmussen, Ruth F. | South Bend | St. Joseph |
| Ratcliff, A. L. | Kingman | Fountain-Warren |
| *Ratcliff, Frank W. | La Fayette | Tippecanoe |
| Ratcliffe, A. W. | Evansville | Vanderburgh |
| Rauschenbach, C. W. | Hammond | Lake |
| Ravdin, Marcus (H) | Evansville | Vanderburgh |
| Rawles, Lyman T. | Fort Wayne | Allen |
| Ray, H. A. | Fort Wayne | Allen |
| Rayl, C. C. | Decatur | Adams |
| Reck, J. L. | Sheridan | Hamilton |
| Records, A. W. | Franklin | Johnson |
| *Redding, Lowell G. | Huntington | Huntington |
| Reed, Ann | Michigan City | LaPorte |
| *Reed, Donald | Culver | Marshall |
| Reed, J. V. | Indianapolis | Marion |
| Reed, L. D. (H) | Hope | Bartholomew |
| Reed, Nelle C. | Michigan City | La Porte |
| Reed, Philip B | Indianapolis | Marion |
| *Reed, R. R. | Indianapolis | Marion |
| Reed, Wm. C. | Bloomington | Monroe |
| *Reeder, H. H. | Jeffersonville | Clark |
| Rees, Russell C. | Indianapolis | Marion |
| *Regan, George L. | Sellersburg | Clark |
| *Reich, Clarence E. | Evansville | Vanderburgh |
| *Reid, Chas. A. | Indianapolis | Marion |
| Reid, Robert W. | Union City | Randolph |
| Reisler, Simon | Indianapolis | Marion |
| *Reiss, Jack | Indianapolis | Marion |
| Reitz, Thomas F. | Evansville | Vanderburgh |
| Remich, A. C. | Hammond | Lake |
| *Renbarger, L. L. | Marion | Grant |
| Rendel, C. F. | Mexico | Miami |
| *Rendel, D. T. | Hammond | Lake |
| Rendel, H. E. | Mexico | Miami |
| Rentschler, L. C. | Clay City | Clay |
| Reppert, Roland | Decatur | Adams |
| Rettig, A. C. | Muncie | Delaware-Blackford |
| *Reul, Thomas W. | Indianapolis | Marion |
| Reusser, Amos (H) | Berne | Adams |
| Reynolds, D. M. | Garrett | De Kalb |
| *Reynolds, F. C. | Indianapolis | Marion |
| Reynolds, F. M. | Montpelier | Wells |
| Reynolds, J. S. | Gary | Lake |
| Reynolds, Richard J. | Salem | Washington |
| Reynolds, R. P. | Garrett | De Kalb |
| *Rhamy, A. P. | Wabash | Wabash |
| Rhamy, B. W. | Fort Wayne | Allen |
| *Rhea, G. D. | Greencastle | Putnam |
| Rhea, James C. | Beech Grove | Marion |
| Rhind, A. W. | Hammond | Lake |
| Rhodes, A. H. | Princeton | Gibson |
| Rhodes, Theodore D. | Indianapolis | Marion |
| Rhorer, H. M. | Kokomo | Howard |
| Rhorer, John G. | | Grant |
| *Rhorer, R. J. | Kokomo | Howard |
| Rice, C. L. | Logansport | Cass |
| Rice, Raymond M. | Indianapolis | Marion |
| Rice, Thurman B. | Indianapolis | Marion |
| Rice, T. R. (H) | Petersburg | Pike |
| Rice, W. B. | Fort Wayne | Allen |
| *Rich, J. S. | Evansville | Vanderburgh |
| Richards, D. H. | Vincennes | Knox |
| Richards, E. E. | Russellville | Montgomery |
| *Richards, Norman F. | Shelbyville | Shelby |
| Richardson, C. L. | Rochester | Fulton |
| *Richart, J. V. | Terre Haute | Vigo |
| Richer, O. H. | Warsaw | Kosciusko |
| Richey, Clifford | Evansville | Vanderburgh |
| Richter, Arthur B. | Indianapolis | Marion |
| Richter, Samuel | Gary | Lake |
| Ricketts, J. W. | Indianapolis | Marion |
| Ridenour, David C. (H) | Peru | Miami |
| Ridgeway, Alton H. | Indianapolis | Marion |
| Ridgeway, O. W. | Indianapolis | Marion |
| Rigg, J. F. | Indianapolis | Marion |
| Riggs, Floyd | Terre Haute | Vigo |
| Rigley, E. L. | South Bend | St. Joseph |
| Riley, E. T. (H) | Greensburg | Decatur |
| Riley, Frank | Jamestown | Boone |
| *Rininger, Harold C. | Christney | Spencer |
| Rinker, E. B. | Indianapolis | Marion |
| Rinne, John I. | Lapel | Madison |
| *Rinne, John I., Jr. | Anderson | Madison |
| Rissing, Walter J. | Fort Wayne | Allen |
| Ristine, Warren H. (H) | Crawfordsville | Montgomery |
| Ritchey, J. A. | Marion | Grant |
| Ritchey, J. O. | Indianapolis | Marion |
| Ritz, Albert S. | Evansville | Vanderburgh |
| Roberts, Floyd N. | Prescott, Arizona | Henry |
| Robertson, A. N. | New Albany | Floyd |
| Ritter, W. L. | Indianapolis | Marion |
| Robertson, D. W. (H) | Deputy | Jennings |
| Robertson, M. O. | Bedford | Lawrence |
| Robertson, Ray | Indianapolis | Marion |
| *Robertson, W. S. | Spiceland | Henry |
| Robinson, Earl U. | Evansville | Vanderburgh |
| Robison, C. A. | Frankfort | Clinton |
| Robison, J. S. | Winchester | Randolph |
| Robrock, Lawrence M. | Michigan City | La Porte |
| Rockey, Noah A. | Fort Wayne | Allen |
| Rodenbeck, Frank | Arcadia | Hamilton |
| Rodin, Herman H. | South Bend | St. Joseph |
| Rodriguez, Juan | Fort Wayne | Allen |
| Rogers, Clarke | Indianapolis | Marion |
| Rogers, Helene B. | Logansport | Cass |
| Rogers, O. F. | Bloomington | Monroe |
| Rogers, R. C. | Bloomington | Monroe |
| Rogers, S. T. (H) | New Albany | Floyd |
| *Rogers, Thomas P. | Indianapolis | Marion |
| *Rohrer, J. R. | Washington | Daviess-Martin |
| Roll, E. C. | Indianapolis | Marion |
| Roller, C. W. | Indianapolis | Marion |
| Rollins, Russell | Royal Center | Cass |
| Romack, H. H. | Greenfield | Hancock |
| Romberger, F. T. | La Fayette | Tippecanoe |
| *Romberger, Floyd T., Jr. | Indianapolis | Marion |
| Rommel, Clarence H. | West Lafayette | Tippecanoe |
| Ropp, E. R. | Oakland City | Gibson |
| Ropp, H. E. | New Harmony | Posey |
| Rose, Bertha | West Lafayette | Tippecanoe |
| Rosenak, Bernard D. | Indianapolis | Marion |
| Rosenbaum, L. E. | Anderson | Madison |
| Rosenblatt, B. B. | Evansville | Vanderburgh |
| *Rosenbloom, P. J. | Gary | Lake |
| Rosenheimer, Geo. M. | South Bend | St. Joseph |
| *Rosenwasser, Jacob | Mishawaka | St. Joseph |
| *Roser, A. J. | Arcola | Allen |
| *Rosevear, Henry J. | Hammond | Lake |
| *Ross, Alexander T. | Indianapolis | Marion |
| Ross, Ben R. | Bloomington | Monroe |
| Ross, Guy E. | Anderson | Madison |
| Ross, H. P. | Richmond | Wayne-Union |
| Ross, L. F. | Richmond | Wayne-Union |
| Ross, Milton S. | Columbus | Bartholomew |
| Ross, W. W. | La Porte | La Porte |
| Rossiter, D. L. | Fort Wayne | Allen |
| Rossman, Wm. B. | Indianapolis | Marion |
| Rossow, R. J. | Evansville | Vanderburgh |
| *Rothberg, Maurice | Fort Wayne | Allen |
| Rothschild, C. J. | Fort Wayne | Allen |
| Rothstein, Emil | Rockville | Parke-Vermillion |
| Rotman, Harry G. | Jasonville | Greene |
| Rotman, Sam | Jasonville | Greene |
| *Row, D. H. | Indianapolis | Marion |
| Row, George S. | Osgood | Ripley |
| Row, Perry Q. | Hammond | Lake |
| Rowe, Howard H. | Rochester | Fulton |
| Royster, George M. | Evansville | Vanderburgh |
| Royster, Hollace R. | Frankfort | Clinton |
| *Royster, R. A. | Evansville | Vanderburgh |
| *Rozelle, Clarence V. | Anderson | Madison |
| *Rubin, Gerald S. | Indianapolis | Marion |
| Rubin, M. R. | Gary | Lake |
| Rubin, Milton M. | Terre Haute | Vigo |
| Ruby, Fred McKemy | Union City | Randolph |
| *Ruch, Monroe K. | Indianapolis | Marion |
| Ruddell, Karl R. | Indianapolis | Marion |
| Ruddick, H. C. | Evansville | Vanderburgh |
| Rudesill, C. L. | Indianapolis | Marion |
| Rudolph, Carl J. | South Bend | St. Joseph |
| Rudolph, F. G. | Hammond | Lake |
| Rudolph, Stephen | Indianapolis | Marion |
| *Rudser, D. H. | Whiting | Lake |
| Ruhmkorff, Ralph H. | Goodland | Jasper-Newton |
| Runyan, H. C. | Alexandria | Madison |
| Rupel, Ernest | Indianapolis | Marion |

| Name | City | County |
|---|---|---|
| Ruschli, E. B. | La Fayette | Tippecanoe |
| Rusk, Hubert M. | Wallace | Fountain-Warren |
| Russell, O. Raymond | Frankton | Madison |
| Russo, John G. | Crown Point | Lake |
| Rust, Byron K. | Indianapolis | Marion |
| Rustin, Edward | South Bend | St. Joseph |
| Ruth, Martin L. | Indianapolis | Marion |
| Rutherford, C. W. | Indianapolis | Marion |
| Ryan, H. J. | Gary | Lake |
| Ryan, L. K. | Gary | Lake |
| *Sage, C. V | Brownstown | Marion |
| Sage, Russell | Indianapolis | Marion |
| Sagel, Jacob | Gary | Lake |
| *Sala, J. J. | Gary | Lake |
| Salb, John A. | Indianapolis | Marion |
| Salb, Leo A. | Jasper | Dubois |
| *Salb, Max C. | Indianapolis | Marion |
| Salon, Harry W. | Fort Wayne | Allen |
| Salon, N. L. | Fort Wayne | Allen |
| Salzman, Morris | Indianapolis | Marion |
| Samples, J. T. | Boonville | Warrick |
| Sanders, I. M. | Greensburg | Decatur |
| Sanders, J. A. | Auburn | De Kalb |
| Sanderson, R. B. | South Bend | St. Joseph |
| *Sanderson, R. J. | Westville | La Porte |
| Sandock, Isadore | South Bend | St. Joseph |
| *Sandock, Louis | South Bend | St. Joseph |
| Sandorf, M. H. | Indianapolis | Marion |
| Sandoz, Harry | South Bend | St. Joseph |
| Sandoz, Louis A. | South Bend | St. Joseph |
| *Sandy, Wm. A. | Indianapolis | Marion |
| Saunders, J. L. | Newport | Parke-Vermillion |
| Savage, A. R. | Fort Wayne | Allen |
| Savery, C. E. | South Bend | St. Joseph |
| Sayers, F. E. | Terre Haute | Vigo |
| *Scales, A. B | Oakland City | Gibson |
| Scamahorn, Malcolm O. | Indianapolis | Hendricks |
| Scamahorn, O. T. | Pittsboro | Hendricks |
| *Scantland, Willard A. | Muncie | Delaware-Blackford |
| Schaaf, Alvin | Jamestown | Boone |
| Schaefer, C. R. | Indianapolis | Marion |
| Schaible, E. L. | Gary | Lake |
| *Schantz, Richard | Remington | Jasper-Newton |
| Schauwecker, Cleon M. | Greencastle | Putnam |
| *Schechter, John S. | Indianapolis | Marion |
| Scheetz, Marion R. | Lewisville | Henry |
| Scheier, E. W. | Indianapolis | Marion |
| Schellhouse, Earl M. | Fort Wayne | Allen |
| Schenck, Foss | Fort Wayne | Cass |
| Schenk, G. H. | Ridgeville | Randolph |
| Scherer, Simon P. (H) | Martinsville | Morgan |
| Scheurich, Virgil | Oxford | Benton |
| Schick, Martin F. (H) | Fort Wayne | Allen |
| Schiller, Herbert A. | Kankakee, Ill. | St. Joseph |
| Schlegel, Edward H. | Fort Wayne | Allen |
| Schlemmer, George H. | Warsaw | Kosciusko |
| Schlesinger, Jacob | Hammond | Lake |
| Schlicker, A. G. (H) | East Chicago | Lake |
| Schlosser, H. C. | Elkhart | Elkhart |
| *Schmidt, Loren F. | Indianapolis | Marion |
| Schmiedicke, P. H. | La Fayette | Tippecanoe |
| Schmitt, Richard K. | Columbus | Bartholomew |
| *Schmoll, Robert J. | Fort Wayne | Allen |
| *Schneider, Carl J. | Indianapolis | Marion |
| Schneider, C. P. | Evansville | Vanderburgh |
| Schoen, P. H. (H) | New Albany | Floyd |
| Schoolfield, Wm. E. | Orleans | Orange |
| Schott, Edward J. | Terre Haute | Vigo |
| Schriefer, E. E. | Cannelton | Perry |
| Schriefer, V. V. | Evansville | Vanderburgh |
| Schuchman, Gabriel | Indianapolis | Marion |
| Schuler, R. P. | Kokomo | Howard |
| *Schulhof, M. G. | Muncie | Delaware-Blackford |
| Schulz, C. H. | Lagrange | Lagrange |
| Schulze, Hans A. | Cumberland | Marion |
| Schulze, Wm. | Vincennes | Knox |
| Schumaker, Robert A. | Terre Haute | Vigo |
| Schuman, Edith B. | Bloomington | Monroe |
| Schutt, J. B. | Ligonier | Noble |
| *Schwartz, David I. | Fort Wayne | Allen |
| Schwartz, W. D. | Portland | Jay |
| Schweitzer, Ada E. | Indianapolis | Marion |
| Scott, Charles C. | Indianapolis | Marion |
| Scott, Frank M. | South Bend | St. Joseph |
| Scott, G. D. | Sullivan | Sullivan |
| Scott, H. V. | Fort Wayne | Allen |
| Scott, Irvin H. | Sullivan | Sullivan |
| *Scott, I. W. | Indianapolis | Marion |
| Scott, R. F. | Kokomo | Howard |
| Scott, R. O. | Charlottesville | Hancock |
| Scott, S. L. | Indianapolis | Marion |
| Scott, V. Brown | Shelbyville | Shelby |
| Scudder, A. N. | Brownsburg | Hendricks |
| Scudder, J. A. | Edwardsport | Knox |
| *Seal, Perry F. | Indianapolis | Marion |
| Seale, Joseph | Fairmount | Grant |
| *Seaman, C. F. | Indianapolis | Marion |
| Sears, M. Maywood | Elkhart | Elkhart |
| Seaton, Albert | Indianapolis | Marion |
| Sedam, Herbert L. | Indianapolis | Marion |
| Segar, Louis H. | Indianapolis | Marion |
| *Selby, K. E. | South Bend | St. Joseph |
| Selsam, Etta B. | Terre Haute | Vigo |
| Senese, T. J. | Gary | Lake |
| Sennett, C. M. | South Bend | St. Joseph |
| Sennett, Wm. K. | Winamac | Pulaski |
| Sensenich, R. L. | South Bend | St. Joseph |
| Senseny, Herbert | Fort Wayne | Allen |
| Sessions, S. K. (H) | Anna, Ill. | Marion |
| *Seward, G. W. | N. Manchester | Wabash |
| Sexson, Hiram | Greenfield | Hancock |
| Seybert, J. D. | Kendallville | Noble |
| Seyler, Anna G. | Crown Point | Lake |
| Shacklett, H. B. | New Albany | Floyd |
| Shafer, J. W. | La Fayette | Tippecanoe |
| Shafer, Marion R. | Indianapolis | Marion |
| *Shaffer, K. L. | Vincennes | Knox |
| Shallenberger, H. R. | Modoc | Randolph |
| *Shanedling, Philip D. | Hammond | Lake |
| Shanklin, E. M. | Hammond | Lake |
| Shanklin, H. L. | Henryville | Clark |
| Shanklin, James | Hammond | Lake |
| Shanklin, V. A. | Terre Haute | Vigo |
| Shanks, Ray W. | Noblesville | Hamilton |
| Shanks, Roy E. | Rushville | Rush |
| Sharp, John L. | Crawfordsville | Montgomery |
| *Sharp, W. L. | Anderson | Madison |
| Shattuck, John C. | Brazil | Clay |
| Shedd, H. B. | South Bend | St. Joseph |
| *Sheehan, Francis G. | Indianapolis | Marion |
| Sheek, Kenneth I. | Greenwood | Johnson |
| Shellhouse, Michael | Gary | Lake |
| Shenk, E. M. | Kokomo | Howard |
| Shepard, Fred F. | College Corner, Ohio | Wayne-Union |
| Sherman, Robert M. | Bluffton | Wells |
| Sherster, Harry | Huntingburg | Dubois |
| Sherwood, J. Vincent | Fort Wayne | Allen |
| *Shields, Jack E. | Medora | Marion |
| Shimer, Wm. | Indianapolis | Marion |
| Shinabery, Lawrence | Fort Wayne | Allen |
| Sholty, L. O. | La Fayette | Tippecanoe |
| *Sholty, W. M. | La Fayette | Tippecanoe |
| Short, John | Fort Wayne | Allen |
| Shortridge, W. H. | Seymour | Jackson |
| *Shortz, Gerald | Kendallville | Noble |
| Shoup, H. B. | Greentown | Howard |
| Showalter, John | Waterloo | De Kalb |
| *Shrader, Jack C. | Indianapolis | Marion |
| Shrock, E. E. | Amboy | Miami |
| *Shuck, Wm. H. | Madison | Jefferson |
| *Shuler, L. L. | Indianapolis | Marion |
| Shullenberger, W. A. | Indianapolis | Marion |
| *Shulruff, H. I. | Hammond | Lake |
| Shultz, H. M. | Logansport | Cass |
| *Sicks, O. W. | Indianapolis | Marion |
| Siebenmorgen, Louis | Terre Haute | Vigo |
| Siekerman, C. W. | Indianapolis | Marion |
| Siekierski, J. M. | Gary | Lake |
| Siersdorfer, T. N. | Indianapolis | Marion |
| *Siewert, O. L. | Logansport | Cass |
| Sigmon, E. L. (H) | Floyd Knobs | Floyd |
| Sigmond, Harvey W. | Indianapolis | Marion |
| Sigmund, Wm. B. | Columbus | Bartholomew |
| *Silbert, David B. | Shelbyville | Shelby |
| Silliman, G. S. | Terre Haute | Vigo |
| Silverburg, S. G. | Evansville | Vanderburgh |
| *Silverman, Norman M. | Terre Haute | Vigo |
| Silvers, J. C. | Muncie | Delaware-Blackford |
| Silvers, J. M. | Muncie | Delaware-Blackford |
| Silvian, Harry | Whiting | Lake |
| Simmons, L. H. | Goshen | Elkhart |
| Simon, A. R. | La Porte | La Porte |
| Simons, J. S. (H) | Lyons | Greene |
| Simpson, Morrell E. | Bedford | Lawrence |
| *Sims, J. Lawrence | Indianapolis | Marion |
| Sims, S. B. (H) | Frankfort | Clinton |
| Singer, E. C. | Fort Wayne | Allen |
| Sink, Frank G. | Remington | Jasper-Newton |
| *Sirlin, E. M. | Mishawaka | St. Joseph |
| Sisson, Helen M. | Pendleton | Madison |
| Skeen, E. D. | Gary | Lake |
| Skillern, P. G. | South Bend | St. Joseph |
| *Skobba, Joseph S. | Butlerville | Jennings |
| Skomp, Claud E. | Marion | Grant |
| Skrentny, Stanley | Hammond | Lake |
| Slabaugh, J. S. | Nappanee | Elkhart |
| Slabaugh, Lotus M. | Nappanee | Elkhart |
| Slaughter, Howard C. | Evansville | Vanderburgh |
| *Slegelmilch, Lorin | Wabash | Wabash |
| *Slick, C. R. | Lynn | Randolph |
| Sloan, H. P. | New Albany | Floyd |
| Slominski, H. H. | South Bend | St. Joseph |
| Sloss, I. H. | Terre Haute | Vigo |
| *Sluss, David H. | Indianapolis | Marion |
| Sluss, John W. (H) | Indianapolis | Marion |
| Small, E. F. | Vincennes | Knox |
| *Smallwood, R. B. | Bedford | Lawrence |
| Smelser, H. W. | Connersville | Fayette-Franklin |
| Smiley, J. H. | Indianapolis | Marion |
| *Smith, B. J. | Kingman | Fountain-Warren |
| *Smith, David J. | Indianapolis | Marion |
| Smith, D. L. | Indianapolis | Marion |
| Smith, E. Rogers | Indianapolis | Marion |
| Smith, Francis C. | Indianapolis | Marion |
| Smith, G. A. | New Haven | Allen |
| Smith, H. Brooks | Bluffton | Wells |
| Smith, H. N. | Brookville | Fayette-Franklin |
| *Smith, H. S. | Gary | Lake |
| Smith, James M. | Nashville | Marion |
| Smith, James S. | Muncie | Delaware-Blackford |
| *Smith, John H. | Bloomington | Monroe |
| *Smith, Joseph S. | Plainfield | Hendricks |
| Smith, L. C. | La Fayette | Tippecanoe |
| Smith, L. W. | Warren | Huntington |
| *Smith, Lawson F. | Indianapolis | Marion |
| Smith, Lester A. | Indianapolis | Marion |
| Smith, Louis D. | East Chicago | Lake |
| Smith, Paul B. | East Chicago | Lake |
| Smith, Paul E. | Richmond | Wayne-Union |
| *Smith, R. A. | New Castle | Henry |
| Smith, R. D. (H) | Bloomington | Monroe |
| Smith, R. Lee | Osgood | Ripley |
| Smith, Roy L. | Indianapolis | Marion |
| Smith, T. J. | Whiting | Lake |
| Smith, W. E. | Decatur | Adams |
| Smith, Wilbur F. | Wash., D. C. | Marion |
| *Smithson, Robert A. | Evansville | Vanderburgh |
| Smoot, E. Brayton | Washington | Daviess-Martin |
| Smoots, S. A. | Terre Haute | Vigo |
| Smullen, Chas. L. (H) | Rushville | Rush |
| *Smullen, Willard C. | Rushville | Rush |
| Sneary, K. D. | Avilla | Noble |
| Snider, Byron | Indianapolis | Marion |
| Snyder, E. R. | Troy | Perry |
| Solomon, R. A. | Indianapolis | Marion |
| Somers, G. H. | Fort Wayne | Allen |
| Souder, Bonnell M. | Auburn | De Kalb |
| Sourwine, C. C. | Brazil | Clay |
| Souter, Martha C. | Indianapolis | Marion |
| Southard, C. B. | Noblesville | Hamilton |
| *Sovine, Joe W. | Indianapolis | Marion |
| Spahr, D. E. | Portland | Jay |
| Spahr, John F. | Indianapolis | Marion |
| *Spalding, J. J. | Indianapolis | Marion |
| *Spalding, W. L. | Mishawaka | St. Joseph |
| *Spangler, Jesse S. | Kokomo | Howard |

| Name | City | County |
|---|---|---|
| Sparks, A. J. | Fort Wayne | Allen |
| *Sparks, Alan L. | Indianapolis | Marion |
| Sparks, Paul W. | Winchester | Randolph |
| *Spaulding, Earl | New Albany | Floyd |
| Spears, John K. | Paoli | Orange |
| *Speas, R. C. | Bloomington | Monroe |
| Speheger, Benjamin A. | Bedford | Lawrence |
| Spencer, Frederic | Vincennes | Knox |
| Spenner, R. W. | South Bend | St. Joseph |
| Spieth, Wm. H. | Lebanon | Boone |
| Spigler, James | Terre Haute | Vigo |
| Spigler, O. R. | Terre Haute | Vigo |
| Spindler, Robert D. | New Castle | Henry |
| Spink, Urbana | Indianapolis | Marion |
| *Spivey, R. J. | Indianapolis | Marion |
| Spolyar, L. W. | Indianapolis | Marion |
| Sponder, Joseph | Gary | Lake |
| Springstun, C. E. | Tennyson | Warrick |
| Springstun, C. L. | Chrisney | Spencer |
| Springstun, George | Oaktown | Knox |
| *Springstun, W. R. | Evansville | Vanderburgh |
| Spurgeon, O. E. | Muncie | Delaware-Blackford |
| Sputb, Carl B. | Indianapolis | Marion |
| Sputb, Carl B., Jr. | Indianapolis | Marion |
| *Staff, R. A. | Rockville | Parke-Vermillion |
| Stafford, J. C. | Plainfield | Hendricks |
| *Stafford, W. C. | Plainfield | Hendricks |
| Stahl, Edward | La Fayette | Tippecanoe |
| Stalker, James B. | Indianapolis | Marion |
| *Stamper, J. H. | Middletown | Henry |
| Stamper, L. Allen | Richmond | Wayne-Union |
| *Stangle, W. J. | Mooresville | Morgan |
| Stanley, J. S. | East Chicago | Lake |
| Stanton, J. J. | Logansport | Cass |
| Stauffer, Walter A. | Elkhart | Elkhart |
| Stayton, C. A. | Indianapolis | Marion |
| *Stayton, Chester A., Jr | Indianapolis | Marion |
| *Stecy, Peter | Whiting | Lake |
| Steele, Brandt F. | Indianapolis | Marion |
| Steele, D. J. | Greencastle | Putnam |
| Steele, E. B. | Crown Point | Lake |
| *Steele, Paul W. | Indianapolis | Marion |
| Steffen, A. J. | Wabash | Wabash |
| Steffen, J. T. | Wabash | Wabash |
| Steinkamp, E. F. | Huntingburg | Dubois |
| Steinman, H. E. | Monroeville | Allen |
| *Stellner, Howard A. | Pendleton | Madison |
| Stemm, W. H. (H) | North Vernon | Jennings |
| Stephens, K. H. | Indianapolis | Marion |
| *Stephens, Lowell R. | Covington | Fountain-Warren |
| Stephens, R. Clarence (H) | Plymouth | Marshall |
| Stephenson, L. E. | Michigan City | La Porte |
| Stern, David H. | Hammond | Lake |
| Stern, Nathan | Indianapolis | Marion |
| Stern, S. L. | Hammond | Lake |
| Stevens, S. L. | Indianapolis | Marion |
| Stewart, Chas. S. | Auburn | De Kalb |
| Stewart, J. H. | Marion | Grant |
| Stewart, Milton B. | Logansport | Cass |
| Stewart, W. E. | Terre Haute | Vigo |
| *Stier, Paul L. | Fort Wayne | Allen |
| Stimson, Harry R. | Gary | Lake |
| Stinson, A. E. | Rochester | Fulton |
| Stinson, Dean K. | Rochester | Fulton |
| *Stirling, E. H. | Indianapolis | Marion |
| *Stiver, Daniel | South Bend | St. Joseph |
| Stocking, B. W. | Muncie | Delaware-Blackford |
| *Stoeffler, Walter | Indianapolis | Marion |
| *Stoelting, V. K. | Winchester | Randolph |
| *Stoen, H. J. | La Fayette | Tippecanoe |
| Stoler, A. E. | Fort Wayne | Allen |
| *Stone, A. T. | Indianapolis | Marion |
| Stone, Charles E. | Bedford | Lawrence |
| *Stone, David F. | Indianapolis | Marion |
| *Stone, Wayne B. | Carmel | Hamilton |
| Storer, Wm. R. | Hobart | Lake |
| Storcy, Joseph L. | Indianapolis | Marion |
| Stork, K. H. | Huntingburg | Dubois |
| *Stork, Urban | Evansville | Vanderburgh |
| Storms, Roy B. | Indianapolis | Marion |
| Stonder, Albert E. | Kempton | Tipton |
| Stout, R. B. | Elkhart | Elkhart |
| *Stout, Walter M. | New Castle | Henry |
| Stover, W. C. | Boonville | Warrick |
| Stoycoff, C. M. | Gary | Lake |
| Strange, Martin B. | New Albany | Floyd |
| Strange, J. W. | Loogootee | Daviess-Martin |
| Straughn, Walter L. | Crawfordsville | Montgomery |
| Straus, David C. | Michigan City | LaPorte |
| Strayer, J. W. | La Fayette | Tippecanoe |
| Streck, F. A. | Lawrenceburg | Dearborn-Ohio |
| Streib, Homer F. | Redkey | Jay |
| Strickland, Karl S. | Owensville | Gibson |
| Strong, Daniel S. | Terre Haute | Vigo |
| *Stroup, Tyler J. | Indianapolis | Marion |
| Stuckman, E. D. | New Paris | Elkhart |
| Studebaker, Lloyd R. | New Paris | Elkhart |
| Study, Joseph N. (H) | Cambridge City | Wayne-Union |
| Stultz, Q. F. | Ligonier | Noble |
| Stygall, J. H. | Indianapolis | Marion |
| *Sudranski, Herbert F. | Indianapolis | Marion |
| Sullenger, A. A. | Indianapolis | Marion |
| *Sullivan, John M. | Terre Haute | Vigo |
| Sullivan, T. L. | Indianapolis | Marion |
| Sutter, Charles C. | Evansville | Vanderburgh |
| *Sutton, Wm. E. | Edinburg | Johnson |
| Suverkrup, Lotta A. | Columbus | Bartholomew |
| Swan, John R. | Indianapolis | Marion |
| Swan, Richard Carl | Indianapolis | Marion |
| Swank, L. Forest | Elkhart | Elkhart |
| Swanson, John | Fort Wayne | Allen |
| Swarts, Willard W. | Auburn | De Kalb |
| Swayne, J. F. | Indianapolis | Marion |
| *Sweet, Howard E. | Richmond | Wayne-Union |
| Swezey, H. N. | La Fayette | Tippecanoe |
| Swihart, L. F. | Elkhart | Elkhart |
| *Switzer, Robert E. | Cromwell | Noble |
| Szabo, S. A. | East Chicago | Lake |
| Take, J. F. | Valparaiso | Porter |
| *Talbott, Dan E. | Indianapolis | Marion |
| Tallman, H. H. | Culver | Marshall |
| Tate, W. W. | Thayer | Jasper-Newton |
| Tavenner, Fred | Gas City | Grant |
| *Taylor, C. C. | Indianapolis | Marion |
| Taylor, D. E. | Velpen | Pike |
| Taylor, E. C. | Upland | Grant |
| Taylor, E. C. | Evansville | Vanderburgh |
| *Taylor, F. W. | Indianapolis | Marion |
| Taylor, J. E. | Leopold | Perry |
| Taylor, L. S. | Elberfeld | Warrick |
| Taylor, W. H. | Ambia | Benton |
| Taylor, W. M. | Crawfordsville | Montgomery |
| Taylor, W. R. | Richmond | Wayne-Union |
| Teaford, S. F. | Paoli | Orange |
| Teague, Frank | Indianapolis | Marion |
| Teal, Dorothy D. | Columbus | Bartholomew |
| Teegarden, J. A., Jr. | East Chicago | Lake |
| Teegarden, J. A., Sr. | East Chicago | Lake |
| Teeter, E. J. | Indianapolis | Marion |
| Teixler, V. A. | Indianapolis | Marion |
| Templin, D. B. | Gary | Lake |
| Tennant, David L. | Fort Wayne | Allen |
| Tennant, L. W. | Larwill | Whitley |
| Tennis, George | Greencastle | Putnam |
| Teplinsky, L. Louis | East Chicago | Lake |
| Terflinger, F. W. | Logansport | Cass |
| Terhune, Rufus W. (H) | Martinsville | Morgan |
| *Terrill, R. W. | Fort Wayne | Allen |
| *Terry, C. C. | South Bend | St. Joseph |
| Teter, Eber | Portland, Oreg. | Henry |
| Teters, Melvin | Middlebury | Elkhart |
| Tether, Joseph E., Jr. | Indianapolis | Marion |
| *Tharpe, Ray | Indianapolis | Marion |
| *Thatcher, H. K., Jr. | Indianapolis | Marion |
| *Thayer, B. W. | North Vernon | Jennings |
| Thayer, J. O. | Indianapolis | Marion |
| Thegse, George | Whiting | Lake |
| Thimlar, J. Wiley | Fort Wayne | Allen |
| *Thom, Jay W. | Spencer | Owen |
| Thom, Julia S. | Spencer | Owen |
| Thomas, C. B. | Plainfield | Hendricks |
| Thomas, C. E. | Leesburg | Kosciusko |
| *Thomas, Everett W. | Leesburg | Kosciusko |
| Thomas, G. A. | La Fayette | Tippecanoe |
| *Thomas, Morris C. | Indianapolis | Marion |
| *Thomas, Morris E. | Indianapolis | Marion |
| Thomas, Ray H. | South Bend | St. Joseph |
| Thompson, A. A. | Tyner | Marshall |
| Thompson, Chas. F. | Indianapolis | Marion |
| Thompson, Holland | Indianapolis | Marion |
| Thompson, J. V. | Indianapolis | Marion |
| *Thompson, John M. | Bremen | Marshall |
| Thompson, Lewis | New Harmony | Posey |
| *Thompson, Paul V. | Indianapolis | Marion |
| Thompson, W. A. | Liberty | Wayne-Union |
| Thomson, J. W. | Garrett | De Kalb |
| *Thornburg, Kenneth | Indianapolis | Marion |
| Thorne, C. E. | New Castle | Henry |
| Thornton, Harold C. | Indianapolis | Marion |
| Thornton, Maurice J. | South Bend | St. Joseph |
| Thornton, Walter | Fort Wayne | Allen |
| Thrasher, John R. | Indianapolis | Marion |
| Thurston, A. L. | Indianapolis | Marion |
| Thurston, H. F. | Indianapolis | Marion |
| Thurston, H. S. | Indianapolis | Marion |
| Tiley, George | Greenwood | Johnson |
| Tindal, E. F. (H) | Muncie | Delaware-Blackford |
| Tindall, Paul R. | Shelbyville | Shelby |
| Tindall, Wm. R. | Shelbyville | Shelby |
| Tinney, W. E. | Indianapolis | Marion |
| Tinsley, W. B. | Indianapolis | Marion |
| *Tipton, Wm. R. | Greencastle | Putnam |
| *Tischer, E. P. | Indianapolis | Marion |
| Titus, Charles | Wilkinson | Hancock |
| Titus, Philip S. | Fort Wayne | Allen |
| Todd, D. D. | Elkhart | Elkhart |
| Tomak, M. E. | Linton | Greene |
| Tomlinson, C. H. (H) | Cicero | Hamilton |
| Topolgus, James N. | Bloomington | Monroe |
| Topping, M. C. | Terre Haute | Vigo |
| *Torrella, J. A. | Indianapolis | Marion |
| Totten, E. C. | Madison | Jefferson |
| Tower, Thomas K. | Campbellsburg | Washington |
| Tracy, J. Ross | Anderson | Madison |
| Tranter, W. F. | Sharpsville | Tipton |
| *Traver, P. C. | South Bend | St. Joseph |
| *Travis, J. C., Jr. | Indianapolis | Marion |
| Travis, Mary Francis | Lafayette | Tippecanoe |
| Tremain, M. A. | Adams | Decatur |
| *Tremor, V. F. | Indianapolis | Marion |
| Treon, James F. | Aurora | Dearborn-Ohio |
| Tripp, H. D. | Winston-Salem, N. C. | Marshall |
| *Trout, C. J. | Lafayette | Tippecanoe |
| Troutwine, William R. | Crown Point | Lake |
| Trusler, H. M. | Indianapolis | Marion |
| Tubbs, George R. | La Fayette | Tippecanoe |
| Tucker, O. A. | Daleville | Delaware-Blackford |
| Tucker, Warren S. | Indianapolis | Marion |
| Tully, J. A. | New Castle | Henry |
| Turley, Verne L. | Fowler | Benton |
| Turner, Anna Goss | Madison | Jefferson |
| Turner, H. B. | Bloomfield | Greene |
| Turner, Oscar A. | Madison | Jefferson |
| Turner, Robert | Muncie | Delaware-Blackford |
| *Tweedall, D. C. | Evansville | Vanderburgh |
| Tweedall, D. G. | Evansville | Vanderburgh |
| Tyler, F. T. | New Albany | Floyd |
| Tyrrell, Thomas C. | Hammond | Lake |
| Underwood, G. B. | Evansville | Vanderburgh |
| *Urschel, Dan L. | Mentone | Kosciusko |
| Utterback, Arnold | Terre Haute | Vigo |
| Valentine, E. J. | Shelbyville | Shelby |
| *Van Arsdall, C. R. | Terre Haute | Vigo |
| Van Bokkelen, Robert | Mooresville | Morgan |
| VanBuskirk, E. L. | La Fayette | Tippecanoe |
| Van Buskirk, E. M. | Fort Wayne | Allen |
| Vance, Walter H. | Fort Wayne | Allen |
| *Vance, Wm. C. | Richmond | Wayne-Union |
| Vanderbogart, H. E. | Goshen | Elkhart |
| Vandevert, Arthur | Sellersburg | Clark |

| Name | City | County |
|---|---|---|
| Vandivier, H. R. | Terre Haute | Vigo |
| Vandivier, R. M. | Indianapolis | Marion |
| *Van Dorf, Nathaniel | East Chicago | Lake |
| Van Kirk, George H. | Kentland | Jasper-Newton |
| Van Kirk, J. A. | Frankfort | Clinton |
| Van Nest, W. A. | Ashley | De Kalb |
| Van Nuys, W. C. | New Castle | Henry |
| Van Osdol, H. A. | Indianapolis | Marion |
| Van Reed, Earl | La Fayette | Tippecanoe |
| Van Ric, L. P. | Mishawaka | St. Joseph |
| Van Sandt, F. A. | Bloomfield | Greene |
| Van Sandt, J. W. | Carbon | Clay |
| Van Vactor, Helen O. | Indianapolis | Marion |
| Van Winkle, Arthur J. | Valparaiso | Porter |
| Varble, Wm. M. | Jeffersonville | Clark |
| Varner, Victor I. | Evansville | Vanderburgh |
| Veach, Lester W. | Bainbridge | Putnam |
| Veazey, Wm. (H) | Avilla | Noble |
| Velkoff, Metodi | Fort Wayne | Allen |
| Venable, George L. | N. Manchester | Wabash |
| Venis, Kemper N. | Muncie | Delaware-Blackford |
| Verplank, Dean T. | Gary | Lake |
| Verplank, G. L. | Gary | Lake |
| Vetter, K. W. | Elkhart | Elkhart |
| Viehe, Robert W. | Evansville | Vanderburgh |
| Vietzke, P. C. F. | Valparaiso | Porter |
| Viney, Charles L. | Logansport | Cass |
| Visher, John W. | Evansville | Vanderburgh |
| Vlaskamp, Elaine | Muncie | Delaware-Blackford |
| Vogel, L. John | Mt. Vernon | Posey |
| *Voges, Edward C. | Terre Haute | Vigo |
| Voisinet, R. A. | Union City | Randolph |
| Vollrath, V. J. | Shelbyville | Shelby |
| Vore, Hugh A. | East Chicago | Lake |
| Vore, L. W. | Plymouth | Marshall |
| Voyles, C. F. | Indianapolis | Marion |
| Voyles, Harry | New Albany | Floyd |
| *Vracin, Daniel | Griffith | Lake |
| Vye, James P. | Gary | Lake |
| Wade, A. A. | Howe | Lagrange |
| Wadsworth, H. C. | Washington | Daviess-Martin |
| Wagner, S. C. | Elkhart | Elkhart |
| *Wagoner, G. W. | Burrows | Carroll |
| Wagoner, Robert H. | Colburn | Tippecanoe |
| Waite, E. L. | Macey | Miami |
| Waldo, J. Thayer | Indianapolis | Marion |
| Wales, E. De Wolfe | Indianapolis | Marion |
| Walker, Floyd B. | Fort Wayne | Allen |
| Walker, F. C. | Indianapolis | Marion |
| Walker, J. L. | La Fontaine | Wabash |
| *Walker, James S. | Indianapolis | Marion |
| *Walker, Robert K. | Indianapolis | Marion |
| Walkinshaw, Wm. (H) | Stillwell | La Porte |
| Wall, Joseph A. | Wabash | Wabash |
| Wallace, E. R. | Aurora | Dearborn-Ohio |
| Wallace, Hawthorne C. | Crawfordsville | Montgomery |
| Wallace, J. C. | Fort Wayne | Allen |
| Waller, John I. | Knightstown | Henry |
| Waller, W. F. | Angola | Steuben |
| Walsh, Edmund N. | Whiting | Lake |
| *Walsh, T. P. | Garrett | De Kalb |
| Walterhouse, H. K. | Ladoga | Montgomery |
| Walters, L. O. | Muncie | Delaware-Blackford |
| Wanninger, Horace | Richmond | Wayne-Union |
| Ward, H. H. | Coalmont | Clay |
| Ward, J. W. | Mishawaka | St. Joseph |
| Ward, Wesley C. | Indianapolis | Marion |
| *Ware, J. R. | Andrews | Huntington |
| Warfel, F. C. | Indianapolis | Marion |
| Warman, A. P. | Indianapolis | Marion |
| Warne, G. H. | Tipton | Tipton |
| Warren, Frank R. | Michigan City | La Porte |
| *Warren, John C. | Bicknell | Knox |
| *Warriner, James B. | Indianapolis | Marion |
| Warvel, J. H. | Indianapolis | Marion |
| Washburn, Richard N. | Rensselaer | Jasper-Newton |
| Washburn, W. W. | La Fayette | Tippecanoe |
| Wasley, Malcolm T. | Muncie | Delaware-Blackford |
| *Watson, Herman L. | Evansville | Vanderburgh |
| Watts, A. A. | Gary | Lake |
| Waymire, E. S. | Indianapolis | Marion |
| Weaver, T. M. | Brazil | Clay |
| *Weaver, Wm. W. | New Albany | Floyd |
| Weber, Edgar H. | Evansville | Vanderburgh |
| Webster, R. K. | Brazil | Clay |
| Weddle, Chas. O. | Lebanon | Boone |
| Weed, Lyle A. | Indianapolis | Marion |
| Weeks, P. H. | Michigan City | La Porte |
| *Weems, M. P. | Jeffersonville | Clark |
| Wegner, W. G. | South Bend | St. Joseph |
| Wehrman, J. O. | Indianapolis | Marion |
| *Weigand, C. G. | Indianapolis | Marion |
| Weil, H. J. | Indianapolis | Marion |
| Weinberg, Samuel | Marion | Grant |
| Weinstein, E. B. | Richmond | Wayne-Union |
| Weinstein, J. H. | Terre Haute | Vigo |
| Weirich, Charles | Butler | De Kalb |
| Weis, William D. | Crown Point | Lake |
| *Weiss, Eugene | South Bend | St. Joseph |
| Weiss, H. G. | Evansville | Vanderburgh |
| Weiss, Jason | Indianapolis | Marion |
| *Weissman, Irving | Fort Wayne | Allen |
| Welborn, J. Y. | Evansville | Vanderburgh |
| Welborn, Mell B. | Evansville | Vanderburgh |
| Weldy, B. P. | Hartford City | Delaware-Blackford |
| Weller, Charles A. | Indianapolis | Marion |
| Wells, Milo C. | Anderson | Madison |
| Welty, S. G. | Fort Wayne | Allen |
| Werry, L. E. | Hartford City | Delaware-Blackford |
| Wesson, Thomas W. | Evansville | Vanderburgh |
| *West, Joseph L. | Indianapolis | Marion |
| Westhafer, E. K. | New Castle | Henry |
| Weverbacher, A. F. | Indianapolis | Marion |
| Whallon, Arthur J. | Richmond | Wayne-Union |
| Wharton, R. O. | Gary | Lake |
| Wheeler, J. T. (H) | Indianapolis | Marion |
| Wheeler, John P. | New Albany | Floyd |
| Whipps, Charles E. | Carlisle | Sullivan |
| Whisler, F. M. | Wabash | Wabash |
| White, C. M. | Clinton | Parke-Vermillion |
| White, C. S. | Rosedale | Parke-Vermillion |
| White, Claude H. | Mooresville | Morgan |
| White, Donald J. | Indianapolis | Marion |
| *White, Harvey E. | Martinsville | Morgan |
| White, I. D. | Clinton | Parke-Vermillion |
| White, James V. | Terre Haute | Vigo |
| White, W. J. | Gary | Lake |
| Whitehead, John M. | Indianapolis | Marion |
| *Whitlatch, Arthur | Milan | Ripley |
| Whitlatch, I. A. | Milan | Ripley |
| Whitlock, Merle E. | Mishawaka | St. Joseph |
| Whitsitt, S. A. | Madison | Jefferson |
| Whitten, Kathryn | Fort Wayne | Allen |
| Wickens, Mary | Richmond | Wayne-Union |
| Wicks, O. C. | Gary | Lake |
| Wiedemann, F. E. | Terre Haute | Vigo |
| Wiggins, D. S. | New Castle | Henry |
| Wiggins, George | New Castle | Henry |
| Wilber, H. R. | Jeffersonville | Clark |
| Wilcox, R. F. | La Porte | La Porte |
| Wilder, G. B. | Anderson | Madison |
| Wildman, R. E. | Peru | Miami |
| Wilhelm, Agatha M. | South Bend | St. Joseph |
| *Wilhelmus, C. K. | Newburg | Warrick |
| Wilhelmus, Charles M. | Newburgh | Warrick |
| Wilhelmus, Wm. M. | Evansville | Vanderburgh |
| *Wilkens, I. W. | Indianapolis | Marion |
| Wilkin, W. Ernest | South Whitley | Whitley |
| *Wilkins, R. W. | Fort Wayne | Allen |
| Willan, H. R. | Martinsville | Morgan |
| *Willett, I. H. | Fort Wayne | Allen |
| *Williams, A. H. | Fort Wayne | Allen |
| Williams, Berniece | New Haven | Allen |
| Williams, Charles D. | Indianapolis | Marion |
| Williams, C. L. | Logansport | Cass |
| *Williams, Everett W. | Columbus | Bartholomew |
| *Williams, F. M., Jr. | Pendleton | Madison |
| *Williams, F. P. | Huntingburg | Dubois |
| Williams, H. O. | Kendallville | Noble |
| Williams, John H. | Muncie | Delaware-Blackford |
| Williams, Luther | Indianapolis | Marion |
| Williams, Paul | Richmond | Wayne-Union |
| Williams, R. H. | Anderson | Madison |
| *Willis, Charles F. | Evansville | Vanderburgh |
| Willis, Joseph H. | Evansville | Vanderburgh |
| Willison, George | Evansville | Vanderburgh |
| Willson, C. L. | Anderson | Madison |
| *Wilson, F. M. | Kokomo | Howard |
| *Wilson, Fred | Terre Haute | Vigo |
| Wilson, Guy | Bicknell | Knox |
| Wilson, J. L. | South Bend | St. Joseph |
| Wilson, J. P. (H) | Scottsburg | Scott |
| Wilson, J. R. | Terre Haute | Vigo |
| Wilson, L. A. | Michigan City | La Porte |
| *Wilson, Leslie | Fort Wayne | Allen |
| Wilson, O. E. | Elkhart | Elkhart |
| Wilson, Paul | Shelbyville | Shelby |
| Wilson, O. R. | Boonville | Warrick |
| Wilson, P. H. | Logansport | Cass |
| Wilson, R. C. | Franklin | Johnson |
| Wilson, Ralph | Evansville | Vanderburgh |
| Wilson, Ralph | Shirley | Henry |
| Wilson, T. L. | Bloomington | Monroe |
| Wiltshire, James W. | Bloomington | Monroe |
| Wimmer, G. G. | Huntington | Huntington |
| Wimmer, Robert N. | Gary | Lake |
| *Winebrenner, J. D. | Columbus | Bartholomew |
| Winstandley, W. C. | New Albany | Floyd |
| Winters, Matthew | Indianapolis | Marion |
| Wisch, L. J. | Whiting | Lake |
| Wise, Charles | Camden | Carroll |
| Wise, Wm. | Indianapolis | Marion |
| Wiseheart, Oscar H. | North Salem | Hendricks |
| Wisehart, Wm. (H) | Colfax | Clinton |
| Wiseheart, Robert | Lebanon | Boone |
| Wiseman, V. Earl | Greencastle | Putnam |
| Wisener, G. H. | Richmond | Wayne-Union |
| Wishard, F. B. | Anderson | Madison |
| Wishard, Wm. N., Jr. | Indianapolis | Marion |
| Wishart, S. W. | Evansville | Vanderburgh |
| *Witkowski, L. J. | La Porte | La Porte |
| Wolfram, Don J. | Indianapolis | Marion |
| Wolfstein, Isabel J. | Indianapolis | Marion |
| Woner, John W. | Linton | Greene |
| Wood, Amelia T. | Muncie | Delaware-Blackford |
| Wood, Charles | Westport | Decatur |
| *Wood, Donald E. | Indianapolis | Marion |
| Wood, E. U. | Columbus | Bartholomew |
| Wood, George | Indianapolis | Marion |
| *Wood, O. L. | Brazil | Clay |
| Whitlock, F. C. | Fairbanks | Sullivan |
| *Wood, R. W. | Oakland City | Gibson |
| Wood, W. B. | Oakland City | Gibson |
| *Wood, W. H. | Evansville | Vanderburgh |
| Woodard, Abram S., Jr. | Indianapolis | Marion |
| Woodcock, C. E. | Greenwood | Johnson |
| Wooden, Edward I. (H) | Rushville | Rush |
| Woods, A. L. | Poseyville | Posey |
| *Woods, H. C. | Markle | Huntington |
| *Woods, James R. | Greenfield | Hancock |
| Woods, W. P. | Evansville | Vanderburgh |
| Woods, Wm. V. | Indianapolis | Marion |
| Wooldridge, Omer | Kokomo | Howard |
| *Woolery, R. H. | Indianapolis | Marion |
| *Work, Bruce A. | Frankfort | Clinton |
| Work, James A. | Elkhart | Elkhart |
| Workman, W. S. (H) | Indianapolis | Orange |
| Worley, A. C. | Fort Wayne | Allen |
| *Worley, J. P. | Indianapolis | Marion |
| Worth, C. W. | Milroy | Rush |
| Wray, C. M. | La Fayette | Tippecanoe |
| Wright, Cecil S. | Anderson | Madison |
| Wright, E. D. | Seymour | Jackson |
| Wright, J. William | Indianapolis | Marion |
| Wright, W. C. | Fort Wayne | Allen |
| Wright, W. W. | New Castle | Henry |
| Wurster, H. C. | Mishawaka | St. Joseph |
| Wyatt, Fred H. | Evansville | Vanderburgh |
| Wyatt, James L., II | Fort Wayne | Allen |

| Name | City | County |
|---|---|---|
| Wyatt, James L. III | Fort Wayne | Allen |
| Wybourn, R. C. | Ossian | Wells |
| Wyeth, Charles (H) | Terre Haute | Vigo |
| Wygant, M. D. | Mishawaka | St. Joseph |
| Wyland, B J. | Mishawaka | St. Joseph |
| Wynn, J F. | Evansville | Vanderburgh |
| Wynne, R. E. | Bedford | Lawrence |
| Wyttenbach, Frederick | Indianapolis | Marion |
| Wyttenbach, John E. | Indianapolis | Marion |
| Yarling, J. E. (H) | Peru | Miami |
| Yarrington, C. W. | Gary | Lake |
| Yeck, C. W. | Evansville | Vanderburgh |
| Yegerlehner, Roscoe | Kentland | Jasper-Newton |
| Yencer, M. W. | Richmond | Wayne-Union |
| Yocum, Boaz (H) | Coal City | Owen |
| Yocum, P. S. | Gary | Lake |
| Yoder, Albert C. | Goshen | Elkhart |
| Yoder, D D. | Columbus | Bartholomew |
| Yoder, Richard P. | Bluffton | Wells |
| York, Arthur F. | Anderson | Madison |
| *Younan, Tom | La Fayette | Tippecanoe |
| Young, E. M. | Sheridan | Hamilton |
| Young, G. M. | Gary | Lake |
| Young, G. S. | Muncie | Delaware-Blackford |
| *Young, John M. | Indianapolis | Marion |
| Young, Ralph H. | Goshen | Elkhart |
| Young, S. J. (H) | Kendallville | Noble |
| *Young, W. C. | Indianapolis | Marion |
| Yung, J. Rudolph | Terre Haute | Vigo |
| *Yunker, P. E. | Evansville | Vanderburgh |
| Zallen, S. G. | East Chicago | Lake |
| *Zaring, B. K. | Columbus | Bartholomew |
| Zehr, Noah | Fort Wayne | Allen |
| Zerfas, L. G. | Merom | Sullivan |
| Zierer, R. O. | Anderson | Madison |
| *Zimmer, Henry J. | Mishawaka | St. Joseph |
| *Zimmerman, Harold | Evansville | Vanderburgh |
| Zimmerman, R. G. | Berne | Adams |
| Zivich, J. M. | East Chicago | Lake |
| *Zweig, E. S. | Fort Wayne | Allen |
| Zwerner, Paul F. | Terre Haute | Vigo |
| *Zwick, Harold | Decatur | Adams |
| Zwickel, R. E. | Newburgh | Warrick |

# Society Reports

## INDIANA STATE MEDICAL ASSOCIATION

### COUNCIL

#### First Meeting

*(French Lick Session, November 6, 1945)*

The first meeting of the Council was held in the Blue Room of the French Lick Springs Hotel, at 8:20 A.M., Tuesday, November 6, 1945; the chairman, Dr. F. T. Romberger, of Lafayette, presiding.

Roll call showed the following members present:

*Councilors:*

First District—I. C. Barclay, Evansville
Third District—A. P. Hauss, New Albany
Fifth District—A. M. Mitchell, Terre Haute
Sixth District—W. U. Kennedy, New Castle
Seventh District—W. L. Portteus, Franklin
Eighth District—E. H. Clauser, Muncie
Ninth District—F. T. Romberger, Lafayette
Tenth District—W. H. Howard, Hammond
Twelfth District—A. Jerome Sparks, Fort Wayne
Thirteenth District—Alfred Ellison, South Bend

*Officers:*

N. K. Forster, Hammond, president.
J. E. Ferrell, Fortville, president-elect.
A. F. Weyerbacher, Indianapolis, treasurer.
E. M. Shanklin, Hammond, editor of THE JOURNAL.

*Members of the Executive Committee:*

Cleon A. Nafe, Indianapolis, chairman.
Albert Stump, Indianapolis, attorney.
T. A. Hendricks, executive secretary.
Ray Smith, assistant executive secretary.

*Member of A. M. A. Board of Trustees:*

R. L. Sensenich, South Bend.

*Delegates to the A. M. A.:*

Don F. Cameron, Fort Wayne.
Norman M. Beatty, Indianapolis (Alternate).
A. M. Mitchell, Terre Haute (Alternate).
A. S. Giordano, South Bend (Alternate).

*General Arrangements Chairman:*

A. P. Hauss, New Albany.

*Legislative Committee:*

Norman M. Beatty, Indianapolis } co-chairmen.
J. William Wright, Indianapolis }

*State Board of Health:*

L. E. Burney, Indianapolis, director.

In honor of the memory of Dr. Ira E. Perry, of the Eleventh District, who passed away June 18, 1945, everyone present rose for a moment of silent tribute.

The minutes of the midwinter meeting of the Council, as published in the March issue of THE JOURNAL, were accepted as printed.

No additions to or comments were made on the formal councilor reports which were printed in the September JOURNAL.

The chairman asked that dates for next year's district meetings be sent to the headquarters' office as soon as possible in order to avoid conflicts.

#### UNFINISHED BUSINESS

*1. Resignation of Dr. George Dillinger, delegate to A. M. A.*

MR. HENDRICKS: I don't know whether or not this would come under unfinished business, but we have a situation which has developed in regard to our delegates to the A. M. A. We have the resignation of Dr. George Dillinger, who is a regular delegate. His alternate is Dr. Giordano. The letter that Dr. Dillinger has written is as follows:

> "I appreciated your letter of October 2 very much. It is true that wherever you go you find Hoosiers, and Thomasville, Georgia, is no exception to that rule, for there are several individuals

here who are transplanted Hoosiers, all in the process of becoming good Georgia crackers.

"I am sorry to be running out on the activities of the Indiana State Association, but feel that I must. Perhaps next year I can get back for the State Association meeting and have a chance to renew old friendships. I am returning my delegate's card to you, for it is probable that the House of Delegates will wish to elect a new delegate since I am leaving the state and have not served during this two-year period. I would be more than happy to attend the Chicago meeting as a delegate, but would not consider it unless I was so specifically authorized. If it is possible, I will try to come to Chicago for the meeting anyway.

"In order that the House may elect a new delegate, I am inclosing a formal resignation to the House of Delegates, if they desire to use it.

"Give everyone my best regards, and tell them that I am sorry not to be present at the annual session."

DR. ROMBERGER: What is the wish of the Council? What is your suggestion, Tom?

MR. HENDRICKS: We discussed this matter with Mr. Stump last night, and maybe he will have some suggestions.

MR. STUMP: It seems to me from the rule of the A. M. A., which is printed on the delegate card itself, that if his resignation is accepted then he could not ask his alternate to serve. Dr. Giordano is his alternate. Dr. Dillinger is still in the Army, as I understand it, and he has expressed in that letter the intention or purpose, if he could, to attend the meeting of the A. M. A. If he were kept on, then Dr. Giordano could serve as his alternate, but if he were removed, then the alternate, it seems to me, would be removed also. If his resignation is not accepted we already have the appointment of his alternate to act in his stead, and that is signed in the presence of your secretary. So, if you do not care to accept his resignation, the effect would be to leave Dr. Giordano there as the delegate, and that, it seems to me, could be a very fortunate solution, and thus let it ride until the two-year period expires.

DR. ROMBERGER: It seems to me that this is the only solution, because why do we have alternates? In the case of death or sickness the alternate functions. I don't see that the House of Delegates or this Council need take any action. How does the Council feel about it?

MR. STUMP: The delegate has signed the card appointing the alternate, so it seems to me that the delegate could not act in the presence of the card, his authority having been exercised to appoint Giordano in his place. It seems that accepting the resignation would not be necessary, because Giordano is there and the delegate could not serve because he had given the functions over to his alternate in this case.

DR. ROMBERGER: What action does the council wish to take?

DR. ELLISON: I make a motion that the council refer this matter to the House of Delegates, where I believe it properly belongs, recommending that Dr. Giordano succeed him as the delegate.

Dr. Portteus seconded this motion.

After further discussion by Dr. Ferrell, Dr. Romberger, Mr. Hendricks, and Dr. Barclay, regarding the length of time remaining of Dr. Dillinger's term, and pointing out that a man no longer a resident of the state should not be a delegate, the motion above-recorded was put before the council and passed.

DR. ROMBERGER: Any other unfinished business?

2. *Resignation of Dr. H. C. Wadsworth, Councilor, Second District.*

MR. HENDRICKS: I have a letter from Dr. Wadsworth:

"A resignation and a request.

"My illness of four years has me down—vertigo and general muscular weakness. I cannot be at the French Lick meeting November 6.

"This is my resignation of all dignities and powers as Councilor of the Second District of the Indiana Medical Association.

"The Councilor to succeed me will be named by the delegates of the constituent counties. He will serve for the years 46-47-48. Will you please see that he is delegated to attend the Council meetings of November 6th and 8th, '45; vacancy resulting from my resignation.

"It had been my hope to finish fifteen years as councilor, but it was not 'in the cards.'

"It is with agreeable memories that I look back upon my fifteen years of association with you. An old shepherd with years of herding a large, timid, forgetful, selfish, changeable, frightened, stampeding herd of mixed-breed Rams has had nothing on you and your job. Indiana Medical Association needs you. Look out for them. But, look out for yourself."

There is a question as to whether or not that election should be made at the first meeting of the House of Delegates or at the regular time at the second regular meeting.

DR. ROMBERGER: What does the council wish to do with this letter of resignation? Is there a motion that it be accepted? I believe that he wants us to accept it.

Dr. Mitchell moved that the resignation be accepted; Dr. Kennedy seconded the motion, and it passed.

DR. ROMBERGER: With the consent of the council the chairman will ask the executive secretary to send a telegram to Dr. Wadsworth, expressing our sympathy and regret as to his illness and inability to be here. Hearing no objection, it is so ordered.

### New Business

1. *Report of the Auditing Committee.*

MR. HENDRICKS: It is published in THE JOURNAL on page 84.

DR. ROMBERGER: Any comments or discussion on the report of the Auditing Committee? The next matter on the agenda is something that the president wishes to bring to our attention:

2. *Appropriation of funds from surplus.*

DR. FORSTER: Mr. Chairman, as you know, according to the Constitution and By-Laws, in order to have an appropriation of funds it is necessary for the Council to approve this appropriation. I would like to bring to your attention this paragraph which I am going to read in my annual report:

"During the year there have been numerous suggestions made by Committees the approval of which, by the Executive Committee, would have entailed the expenditure of various sums of money for which no provision had been made by the Budget Committee. Many of these suggestions are of worth-while character and should be acted upon promptly. Instead, the Executive Committee is forced to approve in principle the suggestions made, but are without power to afford financial assistance toward carrying out the project indicated.

"We have in our treasury a considerable surplus, which lies dormant year after year, and a portion of which might well be put to work to accomplish the various objectives presented as miscellaneous activities. In addition, the present tumultuous transition existing in our national picture, regarding medical practice, leaves a helpless feeling of uncertainty in dealing with problems requiring expenditures where no funds are available.

"Your Executive Committee feels this sense of inadequacy in attempting to deal with such situations. No group can hold back the irresistible currents of change and progress, nor can it influence the direction and destiny of social programs unless it recognizes its responsibilities and affords the indispensible means to influence such forces.

"Therefore it seems most expedient that a fund of $10,000 be appropriated from our surplus, for use at the discretion of the Executive Committee, for the promulgation of such projects as do not normally come under budget requirements. A full accounting of the expenditures made from this fund should be reported to the House of Delegates each year at the annual session, and the depletion of the fund, through expenditures, augmented each year from our surplus in order to return it to the $10,000 level."

This suggestion is going to be made to the House of Delegates, which will handle this report, and I would appreciate an approval from the Council on that project.

DR. ROMBERGER: Any discussion by the Council on this matter? You say it will be presented to the House of Delegates?

DR. FORSTER: Through the regular committee.

MR. HENDRICKS: That will go in through your report to the reference committee.

DR. FORSTER: If I can tell them that it has the approval of the Council, it might be helpful.

MR. HENDRICKS: Expenditures have to come back to the Council from the Finance Committee.

DR. ROMBERGER: I hear no discussion. Item No. 3, under new business. Matters referred from the meeting of November 6:

3. *Loan to* JOURNAL.

MR. SMITH: One matter is the $3,000 loan made to THE JOURNAL, the motion having been made and duly seconded and passed by the Executive Committee, recommending to the Council that the $3,000 loan to THE JOURNAL be transferred to THE JOURNAL account by the action of the Council.

DR. ROMBERGER: What action does the Council wish to take?

Dr. Sparks moved that it be approved; Dr. Kennedy seconded the motion, and the motion carried.

4. *Meeting place for 1946 annual session.*

MR. HENDRICKS: I don't know whether this would come before the Council, but it is a letter from the Indianapolis Convention Bureau, asking that the 1946 meeting come to Indianapolis. I have just met Dr. Wilson in the hall, and he said that there is some discussion by the men in the northern part of the state that they would like to have it come up to the northern part of the state if there were accommodations. He wanted to know if the Inn at Wawasee would be able to take care of the meeting. I couldn't answer him.

DR. SPARKS: The Fort Wayne men have been discussing it.

DR. ROMBERGER: The matter of where the meeting will be held will be handled by the House of Delegates. Any further matters? The question of State Association dues of men assigned to military units: Does the Council want any action on that?

5. *Membership dues problems.*

MR. HENDRICKS: A situation has arisen in two or three cases with men who are with the United States Public Health Service, who have been in the field and attached to and doing duty with regular Army units, and regular combat, and the question has come up before the Executive Committee as to whether those men should have their dues refunded the same as we do for our regular Army and Navy officers who are in regular service. The Executive Committee has felt that this was a matter they could not determine, that it should be put before the Council for final decision.

DR. NAFE: The House ruled a year or so ago that only those men in combat units from Public Health Service would have their dues refunded.

DR. ROMBERGER: The chair would like to ask information. Is it, or is it not true that these men might be in Public Health Service, and be transferred for a month, two months, or indefinitely?

MR. HENDRICKS: They are probably assigned to a regular Army unit, and I suppose those orders could be rescinded at any time, the same as Army officers.

DR. ROMBERGER: He might be in there long enough to get his dues paid and be transferred back, not purposely, but in the ordinary course of events.

MR. HENDRICKS: Do you want me to read a memo that was sent out in regard to this?

"*U. S. P. H. Service Employees.* Physicians in the employ of the United States Public Health Service are not considered in the armed forces unless they are assigned definitely to the Army or Navy. These physicians therefore must pay the regular state association dues."

Dr. Barclay moved that officers so assigned shall be exempt; Dr. Ellison seconded the motion, and the motion was carried.

DR. SPARKS: May I ask, shouldn't it be "Army officers assigned to Public Health Service duty," rather than "Public Health Officers assigned to Army duty?"

MISS KRIBS: They go in as Public Health officers, and later they are assigned to the Army or Navy.

DR. MITCHELL: These men are returning from service, and getting back; they will pay their dues next year, what is the situation on this $5.00 assessment to make up for the dues of the men who were in the service?

DR. ROMBERGER: They immediately become eligible for that assessment.

Following considerable discussion by Dr. Mitchell, Mr. Stump, Dr. Romberger, and others, regarding the length of time the assessment was to run, and the date of the termination of the war, it was decided to have Mr. Hendricks read the original motion made by Dr. Catlett at the second meeting of the House of Delegates last year.

MR. HENDRICKS: "Dr. Catlett: I move that each member be assessed five dollars per year for the duration and one year thereafter."

DR. ELLISON: I wonder if it would not clarify this thing, and carry out the intention of Dr. Wadsworth, to amend this, or recommend to the House of Delegates that it be amended that this amount of money be paid in 1945 and again in 1946, and then be terminated.

Dr. Ellison then made a motion that the Council recommend to the House of Delegates that the $5.00 War Assessment paid in 1945 be continued for 1946, and then terminate. The motion was seconded by Dr. Mitchell, and was carried.

A discussion then followed as to whether or not men just out of service should pay the war assessment.

DR. NAFE: The Executive Committee, in discussing this point last night, made the recommendation that returning service men be billed on the quarterly basis.

Miss Kribs pointed out that about 90 per cent of the men have received their cards by the first of April, and that men coming back next year should receive the same consideration as the men who came back this year, who got their dues gratis.

After considerable discussion it was further decided that a medical officer discharged after January 1, 1946, will not be required to pay 1946 dues. No officer who has served in the armed forces shall be assessed the $5.00 special assessment—date of expiration of terminal leave to be the determining date.

DR. ROMBERGER: Any further discussion? Convention arrangements:

DR. HAUSS: I have no report other than that made to the Executive Committee last night.

6. *Report of chairman of Executive Committee.*

DR. NAFE: Report of the Executive Committee: At your last meeting you empowered the Executive Committee with the responsibility of making such arrangements as were necessary to cover the time lost by Mr. Hendricks when he is employed in Chicago. You are familiar with what has taken place. In other words, Tommy has been secretary of the Council on Medical Service and Public Relations of the A.M.A., giving half time to that and half time to the Indiana State Medical Association, and on March 1, I believe, his salary paid by the state association was placed at half the salary he had received previously. Then, realizing that the amount of work entailed in the office was great, we made this arrangement, which we hope has your approval. At least you gave us the authority of employing Mr. Ray Smith on a part-time basis, beginning June 1st. Mr. Smith, as you know, has been Executive Secretary to Governor Schricker for four years, and our local society in Indianapolis was looking for a secretary. In feeling out what could be done, our local society felt that we could utilize him on a half-time basis, and he could spend the other half with the state association. I want to say to those of you who have not met Mr. Smith that those of us who know him feel that he has done an excellent job, and I would like all of you who haven't met him to know him. This is the arrangement to date. As you recall, Tom was loaned by the Council to the A.M.A. for a trial period of six months. The six months will be up by the first of the year, and what other arrangement is made I think probably should be up to this Council, unless they wish to instruct the Executive Committee further. I will say that I think the only objection is that both of them have been working pretty hard. Tom is working very hard, going up to Chicago and back, and Ray is working hard doing the job for the Indianapolis Medical Society and part-time for the state association. They both have almost two full-time jobs.

The other thing I want to mention is the recommendation of the Executive Committee to the House of Delegates: As you know, two years ago the House of Delegates authorized the Legislative Committee to pass an annual registration law and limit it to $1.00. Nobody has been very happy about that $1.00 feature, and the Executive Committee would like to call to the attention of the Council and the House of Delegates the fact that $1.00 is not adequate. It probably should have been $2.00, and we hope they will give the Legislative Committee the power to make the law to change that to $2.00. I have a long list of reasons, which Miss Kirk gave me, which I will not enumerate except to say that the State Board of Medical Registration is the only board of a similar nature that does not have an annual registration fee. Thirty of the forty-eight states have an annual registration fee.

One is as high as $25.00, but the average fee is about $2.00 or $3.00. For your information, the State Board of Medical Registration gets about $6,000 a year from all its fees. They have had a little more than that, but they can't do much with $6,000. In fact, Miss Kirk tries to do about all the work, and she really can't do it. Six thousand dollars is the only revenue they have, and this would give them at least $6,000 more.

Another thing I wish to call to your attention is the question of malpractice insurance. A year ago, about this time, we started, on authorization of the Council, and the House of Delegates' specific instruction, a group-coverage contract with the St. Paul Indemnity Company. To date they have not had as large a group in that company as we had hoped. In order to make a good showing and reduce the premium as soon as possible, they gave their agents only 10 per cent, and an agent in a town selling Aetna or any other good contract is a little loathe to give up that business with a higher commission and sell for some other company at 10 per cent, so they have changed that to pay the regular fee. To date they have had very good experience. They have had practically no loss, but they had hoped to have a little larger group, and a little longer time to determine what that loss was going to be, and asked if they couldn't continue the same fee for another year, which will give them two years' experience. You realize that a lot of that business has straggled in, so they really haven't had it for a whole year. They would like two years in which to determine what the loss ratio is going to be, at which time they feel they can substantially reduce the premium under that contract.

I have talked to Dr. Barker of Connecticut, the secretary of the Oklahoma society, and a physician in New York, who have group coverage with various companies. They all are very delighted with their group coverage because of the fact that they have reduced the premium after a few years, and they have gotten adequate and satisfactory coverage. I believe, Mr. Chairman, that that is all.

DR. ROMBERGER: Thank you, Dr. Nafe. Any discussion?

DR. MITCHELL: I would like to make a motion that the present set-up of Mr. Hendricks with the state society and the A.M.A. be continued for at least another year, because I think it puts Tom at an advantage to have the two positions. I make the motion that it continue for another year.

Dr. Howard seconded the motion.

DR. MITCHELL: I make a motion that Mr. Hendricks be continued another year in his present status, contingent upon the arrangement in Chicago (if the thing in Chicago falls through, Tom comes back to his job) and that we also continue the arrangement with Mr. Smith.

DR. ROMBERGER: It has been moved and seconded that the Council approve the arrangement in the headquarters office, to continue the services of Mr. Hendricks and Mr. Smith.

The motion carried.

DR. MITCHELL: Concerning the registration fee, I move that the fee be left up to the Executive Committee to determine whether it shall be $1.00 or $2.00.

DR. PORTTEUS: I want to make an amendment—that the Council go on record as being in favor of $3.00.

DR. MITCHELL: I recommend that it be left up to the Council.

DR. ELLISON: Has the Board of Registration indicated what it will need?

DR. MITCHELL: I withdraw that motion.

DR. ROMBERGER: Any further discussion?

7. *Additional Council meetings.*

DR. SPARKS: May I say something? This is something I have been thinking about for some time. Membership in the Council used to be a sort of honorary job. Now it requires a lot of hard work. We have a meeting during the annual session, and again in January, and there is a long lapse in between. We are given a lot of things to consider in a short period of time and we are not prepared for it, and I don't think we do justice to the job. It is my feeling we would do a much better job, especially with the prospect of additional work being thrown on to the Council, if we were to meet at least four times a year. If that is the feeling of the other members, I suggest that an amendment be proposed this afternoon, which could be passed at this session, because it involves only an amendment of the By-laws to take effect immediately.

Dr. Ellison made a motion that the Council meet four times a year; Dr. Kennedy seconded it, and the motion carried.

8. *Report of Legislative Committee.*

DR. BEATTY: You all have read in the press concerning the death of Dr. Richards of Patricksburg, who was a member of the Legislature for several sessions. For that same number of sessions Dr. Richards was chairman of the Health Committee in the House, which was very helpful. . . . Gentlemen, I feel the loss of Dr. Richards very keenly—would it be out of order, Dr. Romberger, for us to pay a moment's respect to the memory of the many hours he spent in our welfare?

DR. ROMBERGER: The Council will arise for a moment of respect. The chair will direct the secretary to wire Mrs. Richards on behalf of the Council of the Indiana State Medical Association.

DR. ROMBERGER: Now, the Health Insurance report by Dr. Kennedy:

9. *Report of Committee on Prepayment Insurance.*

DR. KENNEDY: Another thing which directly affects us, Wagner, in his original discussion and introduction of the bill, said it would not be imposed as a general thing on all the population, but would use the existing institutions to carry it out, just as was done in England.

The one lesson to be drawn from that is that the quicker we get an organization going, the more likely we are to benefit. I am somewhat embarrassed. The House of Delegates had a special meet-

ing, and directed that a prepayment plan on an indemnity plan be approved, but the Committee voted for a service plan. It will be necessary in reporting that I make a motion of carrying that out unless the chair rules that the matter has already been settled.

Let it be distinctly understood that the Indiana State Medical Association cannot organize a plan. The charter prohibits that. The proposal will be that the organization plan be put in the hands of the Council. If that carries on Thursday morning, we shall be prepared to offer you a plan. Some investigation has been made, following a suggestion by Dr. Crockett. I have always been afraid it would be difficult to raise money. Last week I sent out forty letters to various men, asking their reaction. The replies from that, up until Saturday, indicated that we know where we can lay our hands on $30,000 immediately. There are others letters I haven't seen, but that particular part of raising the money can easily be done. We shall make our report this afternoon. You can rule as to what motion can properly be presented. We must take final, decisive action; if we are going into this thing, let us do it now, and by the first of the year we may have an organization working.

Dr. Romberger: The postwar program of the State Board of Health:

10. *Postwar program of State Board of Health.*

Dr. Burney: We have several programs that we hope to put into operation in the next two years. One of the most pressing problems we have, which I discussed with Dr. Forster briefly yesterday, concerns a hospital survey for the State of Indiana. We are receiving inquiries from communities in the state every day, wanting to know if we can help them on their hospital needs. They state they are losing their young doctors. There is a county in southern Indiana in which the only young physician was leaving the community because he stated he couldn't practice good medicine in the absence of a hospital. The community organized a committee and came to see us, to learn how many beds they needed, and if we could give them some basic plans. That is true in a number of other communities in the state. We have been directed by the legislature to make a survey of hospital needs in Indiana, to determine from this data the sufficiency of hospital beds, general, tuberculosis, and mental hospitals, and then to prepare a master plan which would give to the state the additional needed facilities. This is a pretty big job.

We have had six regional meetings throughout the state. We selected two or more councilor medical districts, to compose these six regions. We asked the hospital administrators, councilors of the association, and trustees of the dental association to come to the meetings in Indianapolis, Evansville, New Albany, Gary, Lafayette, and Fort Wayne. We told the people the background of our Indiana bill, the possible need in Indiana, and then explained the hospital schedule which we were asking them to complete. Those schedules will be completed and picked up by our staff members within the next month. That is the easiest part of the survey. The most important part is the evaluation of that material and the preparation of an intelligent plan to supply the needs which exist in Indiana.

I discussed briefly with Dr. Forster who he thought would be desirable to have on an advisory committee, to evaluate the data collected and to prepare an intelligent and equitable plan. We believe that this committee should consist of ten or twelve individuals. We would like to have representation from industry, agriculture, labor—not only to give general representation on the committee for our state, but if any of the hospitals in our state desire to take advantage of federal assistance, through the Hill-Burton Bill, it is necessary that the Governor appoint members representing such groups.

Dr. Forster and I discussed this briefly. We were thinking about three physicians, and, of course, a physician would be the chairman of the committee, perhaps two hospital administrators, a representative from agriculture, labor, industry, and possibly the American Legion, and Federation of Women's Clubs—although these last two were not definite.

There are many communities in the state that do not want to take advantage of any federal grants and aid. They feel that they are able themselves to pay for anything, and they do not want to be affected by any restraint which may accompany federal grants. There are a number of communities, however, that do want to take advantage of funds if they become available through the Hill-Burton Bill. I suspect that you are familiar with this bill; it is a hospital construction bill that has received the support of the A.M.A., the American Hospital Association, and various other groups.

As far as I can learn, the only restraints that will be attached to such funds are two: First, that the plan submitted by the community must conform to the over-all, coordinated state plan that has been prepared by this advisory group, working with the Board of Health. In other words, if a community in the southern part of the state submits hospital plans, and this advisory group states that they don't need more hospital beds in that community, then the state agency will disapprove those, and they cannot receive a federal grant. The other restriction that we see attached to it (there may be others later), is that the plans of this hospital must be approved by the federal agency and must conform to reasonable hospital standards.

The Hill-Burton Bill is, I believe, on the floor of the Senate now. The original grant was for $100,000,000 a year. That has been cut to $75,000,000 a year for the next five years. I received some information in Washington last week (and this isn't official yet) that Indiana's share, if $75,000,000 is passed, will be approximately $1,600,000 the first year, and that the funds will be granted on the basis of population and economic need in the states. On that basis the grants to the hospitals in Indi-

ana will be on an approximate basis of 40-50 per cent.

We do feel that this is the most important problem we have in the State Board of Health at the present time. We have on the average in Indiana 2.7 hospital beds per thousand population. That is not considered adequate. We know that some communities have as low as one bed per thousand population. With the awakened interest of the public in hospital planning, we believe some intelligent group should help them, so they will not prepare a haphazard plan, and that is why we have asked Dr. Forster to advise us as to the group who should use the data that we are now gathering, in order that we may have an intelligent hospital program for the state.

In this same county I was telling you about, we have two cities, each with a population of five thousand. They both want a hospital, and they both formed hospital committees, and it will be up to this advisory board to say whether one town needs it or the other. In other words, it is going to take considerable fortitude not only to prepare the plan, but to stand back of it. Dr. Clauser is familiar with hospital licensure and the progress that has been made. Regulations are being prepared by the hospital council now, and at the next meeting, a week from this Thursday, the hospital council meets with the State Board of Health, to approve the proposed regulations jointly. Then we have to hold hearings on these before they can be officially promulgated.

Just one other point: we are quite interested in the development of local health departments manned by full-time, well-qualified physicians, nurses, and engineers. We have about 192 part-time health officers in Indiana. They have all done a splendid job, but all with whom I have talked have stated that they are inadequate to cope with the health problems in their communities. They do not have the time or the personnel to perform the job. I believe that the Indiana State Medical Association has endorsed the establishment of local health departments, manned by full-time people. We do not have the personnel yet; we do not have the physicians even to fill some of the positions on our own State Board of Health, but we do believe that one of the main objectives of our State Board of Health is, and should be, the promotion and establishment of full-time health departments, under the direction of a qualified physician who spends all of his time and energies in a public health program.

In attempting to give a little better service from the State Board of Health, we are decentralizing our activities. We are planning to establish five large state districts, covering the entire State of Indiana. We have tentatively set the district headquarters in Washington, Bloomington, Columbus, Valparaiso, and either Huntington or Fort Wayne, probably Fort Wayne. In those state districts, and we do want to emphasize that they are state districts and do not take the place of local health districts, we have certain responsibilities, such as water, sewage, dairy products, food, and drug, that we perform now from the state level. We will put in those districts a physician who will be the district director. Under him will be a sanitary engineer, one or two consultant nurses, a dairy products sanitarian, a food and drug sanitarian, and a health specialist. We feel that the people working in those eighteen or twenty counties can become better acquainted with the problems and the people, and thereby give a much better service. We want it understood that these state districts are not replacing full-time local districts. We feel that problems of public health are community problems, and the machinery for their solution should be set up in the local community, under local direction and local administration. We want your comments at any time. If some of our people stub their toes occasionally, as we all do, we are open to suggestions and criticism at all times. We need your help. We believe that your endorsing our local public health program will go a long way toward helping us establish these, and perform the services that our people in Indiana need in public health. Thank you very much for the privilege of talking to you.

Dr. Romberger: Thank you.

Dr. Forster: I understand that the appointment of this advisory committee is to be made by the Governor, and that three doctors will function on that committee. Because of the importance of the proposed plan, not only from the standpoint of the survey itself, but also from the fact that the various states are likely to use federal funds to erect some of these hospitals and health centers, I think it is important that we should receive some comments from the various councilors as to who they would suggest, in the various districts, be appointed on this committee, or rather suggested for the Governor's appointment. After each councilor has suggested a name, I think the districts may be divided into North, Middle and Southern Sections, and that perhaps one man be selected to represent the three sections of the state. I am supposed to suggest these names, and I would appreciate the help of the councilors in having their suggestions.

Mr. Stump: Another matter I would like to suggest. Maybe the council would want to consider it; maybe not. I have had some correspondence with doctors out in the state, in those areas in which they are not wanting to use federal funds. Dr. Burney knows of the situation with respect to some of those communities. They have written to me about state laws regarding the organization of hospitals where they would not have any connection with federal funds—organize their own hospital independent of the survey that might be made. I am not sure that the medical profession is very familiar with the Hospital Council Bill which passed the last session of the legislature. There is this limitation on their building their own hospital locally: any hospital, under the new hospital law, will be required to have the approval of the hospital council, so if they attempted to build it locally it would still require approval.

I also made this suggestion, when receiving inquiry about the method of procedure of organizing their own, outside of federal aid: they should not overlook the fact that if it was to be built at public expense locally, if they have a high tax rate already there might be some unfavorable developments; and that might be unfavorable, too, with respect to the medical group locally, if they got started on a thing that was entirely locally-supported, when the community, if they had not taken that particular method, might have had the same thing without local tax or with less local tax. I made that suggestion as something to keep in mind when they proceed with the local plan; and I also called attention to the fact that they could not organize a hospital which would need to use public funds for its construction or maintenance, without having the approval of this council which is to be appointed. I mention these things as among the problems involved in connection with these hospitals. This committee will be an important one, and this should be considered in appointing the physicians.

11. *Election of Editor of* THE JOURNAL *for 1946, and Editorial Board members.*

Dr. Kennedy moved that Dr. E. M. Shanklin be re-elected as editor of THE JOURNAL. Dr. Ellison seconded the motion, and it carried.

DR. ELLISON: I should like to make a few remarks in connection with the editorship of THE JOURNAL. It occurs to me that Dr. Shanklin is not going to be with us always. He has done an outstanding job, and some day he is going to become ill, or whatnot, and as the Council is responsible for the publication of THE JOURNAL, it might be embarrassed suddenly to have the editor step out of the picture. It would seem appropriate if we gave some thought to the appointment of an associate, who might not be remunerated, but one who could be brought up and trained by Dr. Shanklin, so that in the event of his stepping out of the picture we would have someone to whom we could turn.

DR. ROMBERGER: Any comment?

DR. SPARKS: I think Dr. Ellison's point might well be considered. A situation like that came up with *The Journal of Urology*. Dr. Young had been editor for a long time. There was an associate editor, who during Dr. Young's illness took over, and Dr. Young still carried on as editor, but in case of emergency the other man was responsible for it. He didn't take any very active part during Dr. Young's activity.

After some discussion Dr. Ellison made a motion that a committee be appointed to discuss this matter with Dr. Shanklin, and bring back to the Council recommendations on this point. Dr. Sparks seconded the motion, and it carried.

DR. ROMBERGER: I appoint Dr. Mitchell as chairman, Dr. Ellison, and Dr. Howard. We will expect a report on this Thursday morning. We will now select two members for the Editorial Board, to succeed Dr. Rupel and Dr. Garton, replacements from the Seventh and Twelfth districts.

A ballot was taken, and Dr. F. R. N. Carter, of South Bend, and Dr. E. L. Bulson, of Fort Wayne, were elected to serve for three years.

DR. ROMBERGER: The last item is to set a date for the midwinter meeting of the Council.

12. *Date of midwinter meeting of Council.*

Dr. Mitchell made a motion, which was duly seconded, that the meeting be held at 9:00 A.M., January 13, 1946, and that the Secretaries Conference be held on the same date. The motion carried.

Mr. Hendricks announced that, in addition to the party for the Governor, all members of the Council, officers of the state medical society, and members of the House of Delegates were invited to a party by the Schenley Laboratories, Wednesday, at 4:45 to 6:30, in Room 338. He asked the councilors to register immediately to avoid the rush in the afternoon, and expressed appreciation for both Mr. Smith and himself for the action of the Council in making arrangements so that they can continue to work at their respective jobs, and assured the Council that the first interest of both of them is the Indiana State Medical Association.

The Council then adjourned until Thursday morning, following the second meeting of the House of Delegates.

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## THE COUNCIL

### Second Meeting

*(French Lick Session, November 8, 1945)*

The second meeting of the Council convened immediately following the adjournment of the House of Delegates, Thursday morning, November 8, 1945.

DR. FORSTER: The action of the House of Delegates, I believe, was to accept Dr. Romberger's resignation as chairman of the Council. To make it perfectly satisfactory all the way around, the chair will entertain a motion to accept the resignation of Dr. Romberger.

Such motion was made by Dr. Ellison, seconded by Dr. Sparks, and carried.

Dr. Sparks then nominated Dr. Mitchell as chairman pro tem, in order to carry on the affairs of the Council. Dr. Hauss seconded the motion, and the motion carried.

Roll call showed the following members present:

*Councilors:*

First District—I. C. Barclay, Evansville
Second District—J. H. Crowder, Sullivan
Third District—A. P. Hauss, New Albany
Fifth District—A. M. Mitchell, Terre Haute
Sixth District—W. U. Kennedy, New Castle
Seventh District—W. L. Portteus, Franklin
Eight District—E. H. Clauser, Muncie
Ninth District—Wemple Dodds, Crawfordsville
Tenth District—W. H. Howard, Hammond
Eleventh District—C. S. Black, Warren
Twelfth District—A. Jerome Sparks, Fort Wayne
Thirteenth District—Alfred Ellison, South Bend

*Officers:*

N. K. Forster, Hammond, president.
J. E. Ferrell, president-elect 1945, Fortville.

F. T. Romberger, Lafayette, president-elect 1946.
A. F. Weyerbacher, Indianapolis, treasurer.

*Members of Executive Committee:*

C. A. Nafe, Indianapolis, chairman.
C. H. McCaskey, Indianapolis.
Albert Stump, Indianapolis, attorney.
T. A. Hendricks, executive secretary.
Ray Smith, assistant executive secretary.

*Member of A.M.A. Board of Trustees:*

R. L. Sensenich, South Bend.

*Delegates to the A.M.A.:*

F. S. Crockett, Lafayette.

*State Board of Medical Registration and Examination:*

Paul Tindall, Shelbyville.

*Guest:*

Creighton Barker, M.D., Secretary, Connecticut State Medical Society, New Haven.

### PREPAYMENT INSURANCE

Dr. Mitchell: The first thing to come up before the Council is the consideration of the details on prepayment insurance. The indemnity plan has been handed to us by the House of Delegates in its resolution of day before yesterday. I would like to hear you discuss that subject.

This was discussed by Drs. Portteus, Sparks, Hauss, Crockett, Howard, Ellison, Nafe, Mitchell, Forster, Sensenich, Kennedy, Barclay, Barker (of Connecticut), Mr. Stump, and Mr. Hendricks.

Dr. Portteus proposed the following motion and resolution: That the Council shall designate six incorporators directed to incorporate an indemnity company, either a mutual or stock type of company. He stated that he was presenting this merely to get some working basis, to get this matter started. Dr. Howard seconded this motion.

Dr. Portteus withdrew the above motion in the interest of clarity, restating it as follows: That we appoint a committee from the Council of about six members, to draw up the details of a plan which must be decided here, whether it be mutual or stock, and submit this plan to a specially-called meeting of the Council sometime in December.

Dr. Kennedy seconded the motion.

Dr. Hauss amended the motion to make it a committee of three, and the motion carried.

Dr. Kennedy then moved, and Dr. Portteus seconded it, that the committee be directed to prepare a plan based upon a stock company.

The chairman asked for a vote on the motion of a stock company. One was for it, eight were against it.

Dr. Sparks then made the motion that the committee that is appointed draw up a plan for both the stock type of company and a mutual type of company, and report back to the Council at the earliest opportunity at a special meeting. Dr. Kennedy seconded the motion, and it carried.

The chairman appointed Dr. Kennedy, Dr. Howard, and Dr. Portteus on that committee, and set December 16, 1945, as the date to report back.

### RESOLUTION BY STATE BOARD OF MEDICAL REGISTRATION AND EXAMINATION

Dr. Mitchell: Dr. Paul Tindall has something to say.

Dr. Paul Tindall: I apologize for my presence here while you were discussing other matters. The last time I met with you was to discuss the very same subject I want to mention today; opposition to the provisions of House Bill No. 176, which the Council decided it would not oppose. This Act provides for the practice of *medicine* in addition to osteopathy by those osteopaths who successfully pass an examination in materia medica before the State Board of Medical Registration and Examination. The present medical members of the Board have discussed this matter several times in an attempt to solve this most difficult problem. Since the passage of this Bill, many applicants from other states have corresponded with the Board regarding reciprocity, with the idea that they can practice *medicine* in Indiana. The law is not yet operative. Until the laws are published and distributed this law is not in effect. Dr. Ruddick was here yesterday. I am sorry we could not discuss this matter with you while he was here. However, we decided to ask the Council to be kind enough to petition the State Board of Registration and Examination, in effect, as follows:

"Indiana State Board of Medical Registration and Examination:

#### RESOLUTION

"Whereas, the Indiana State Legislature, during its 1945 session, passed a law providing for the practice of medicine by osteopathic physicians, under the same terms and conditions as apply to graduates of approved medical colleges, therefore, Be it Resolved:

"That, the Council of the Indiana State Medical Association petition the Indiana State Board of Medical Registration and Examination to adopt a resolution concerning the administration of this Act, in substance, as follows:

"Whereas, it now becomes the duty of the Indiana State Board of Medical Registration and Examination to administer the aforementioned law, House Bill No. 176 of the Acts of 1945, whereby osteopathic physicians may be licensed to practice osteopathy, *medicine*, surgery, and obstetrics, on the same terms and conditions as those licensed to practice medicine, surgery, and obstetrics, Therefore, Be it Resolved,

"That, each and every applicant for a certificate to practice osteopathy, *medicine*, surgery, and obstetrics be required to have successfully passed an examination in materia medica in a medical school, approved by the Indiana State Board of Medical Registration and Examination, said examination having been successfully passed as a prerequisite to graduation from

said approved medical school, before the applicant is admitted to examination before the Indiana State Board of Medical Registration and Examination."

DR. HOWARD: I move the acceptance of the report.

Dr. Portteus seconded the motion, and it carried.

#### AVAILABLE SURPLUS FUND

DR. FORSTER: The House of Delegates this morning approved the report of the Reference Committee on the Report of Officers, and included in that was the Report of the President. I think you will recall that at our first meeting the other day, at the meeting of the Council, I suggested that a fund of $10,000 be appropriated from the surplus, to be set up for the use of the Executive Committee to take care of emergency measures. Since the House of Delegates has now approved the recommendation made in that report, I should like to ask the Council, to which it is now referred, according to the Constitution and By-laws, if it will not consider the approval of this amount. I would like to say that I feel some such action is necessary, because there are continually matters coming up for which there is no provision in the budget.

Dr. Black made a motion of approval; seconded by Dr. Hauss, and carried.

#### COMMITTEE ON HOSPITAL CONSTRUCTION

DR. FORSTER: Do you remember that Dr. Burney requested that we present the names of three doctors to serve on this Advisory Committee which would be appointed by the Governor, on the licensing and building of hospitals, etc.? I asked the members of the Council if they would each suggest a name to me. I would like to have as many of those names today as possible, as it will save writing later. When all of the Councilors have suggested a name, we will choose a man from the South, a man from the Middle Section, and a man from the North.

This committee will be appointed by the Governor, and on that committee he plans to have twelve men. There will be three physicians, one dentist, one nurse, and two hospital administrators, so if the medical end of the thing sticks together, it should be able to control the acts of that committee.

#### ASSOCIATE EDITOR OF JOURNAL

DR. ELLISON: Dr. Shanklin wanted each of the councilors to submit one or more names for an associate editor.

DR. MITCHELL: Dr. Ellison, Dr. Howard, and myself were appointed to talk with Dr. Shanklin about an associate editor. He was receptive; had no objection. He selected one man who refused to take the job, and he has now asked that each councilor suggest the name of someone they feel has editorial ability, or journalistic ability, and submit the name to him for consideration, along with Tom, for an associate editor. If you have anybody in mind, you should send the name in to Mr. Hendricks, so that it can be given to Dr. Shanklin for consideration. Do that as soon as possible, so this man can be appointed. The official designation is to be left to Dr. Shanklin.

#### SERVICEMEN'S RESOLUTIONS

DR. NAFE: I want to call to your attention the resolution from Dr. Smith, for servicemen. Many of those things are now being done by the state association, but I hope you will not forget the request of that group to the Council.

Dr. Mitchell suggested that copies be sent to everyone, of the report from the Executive Medical Officer of the Armed Forces, for consideration, so it can be discussed at the Council meeting on December 16. This was taken by consent.

#### SPECIAL COUNCIL MEETING, DECEMBER 16, 1945

There being no further business, the Council adjourned to meet at a 12:30 luncheon, on December 16, 1945, in Indianapolis.

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## INDIANA STATE MEDICAL ASSOCIATION

### HOUSE OF DELEGATES

*(French Lick Session, 1945)*

#### First Meeting

The first meeting of the House of Delegates of the 1945 session convened in the Main Convention Hall, French Lick Springs Hotel, at 1:45 P.M., Tuesday, November 6, 1945; the president, Dr. N. K. Forster, of Hammond, presiding.

A motion was made, duly seconded, and carried, to dispense with roll call, and to have the attendance slips which were distributed constitute the roll call of the House. These slips showed the following members present:

#### DELEGATES

| *County* | *Delegates* |
|---|---|
| Adams | Myron L. Habegger, Berne |
| Allen | M. B. Catlett, Fort Wayne |
| | M. R. Lohman, Fort Wayne |
| | H. Vaughn Scott, Fort Wayne (Alternate) |
| | Wm. C. Wright, Fort Wayne |
| Bartholomew | Lowell F. Beggs, Columbus |
| Boone | Ralph J. Harvey, Zionsville |
| Cass | E. B. Jewell, Logansport |
| Clark | J. T. Carney, Jeffersonville |
| Clay | J. F. Maurer, Brazil |
| Dearborn-Ohio | J. C. Elliott, Guilford (Alternate) |
| Decatur | I. M. Sanders, Greensburg |
| Delaware-Blackford | Clay A. Ball, Muncie |
| | Bruce W. Stocking, Muncie (Alternate) |
| Dubois | S. L. McKinney, Huntingburg |
| Fayette-Franklin | E. M. Glaser, Brookville |
| | F. B. Mountain, Connersville |
| Floyd | C. E. Briscoe, New Albany |
| Fulton | A. E. Stinson, Rochester |
| Gibson | C. M. Clark, Oakland City |
| Grant | R. W. Lavengood, Marion |
| Hamilton | R. F. Harris, Noblesville |
| Hancock | Joseph L. Allen, Greenfield |
| Harrison | William E. Amy, Corydon |
| Hendricks | O. T. Scamahorn, Pittsboro |
| Henry | C. E. Canaday, New Castle |
| Huntington | G. M. Nie, Huntington |

| *County* | *Delegates* |
|---|---|
| Jasper-Newton | W. G. Pippenger, Brook |
| Jay | George V. Cring, Portland |
| Jennings | D. W. Matthews, North Vernon |
| Knox | C. L. Boyd, Vincennes |
| Lake | H. W. Eggers, Hammond |
| | C. M. Jones, Whiting |
| | P. Q. Row, Hammond |
| Lawrence | Claude Dollens, Oolitic |
| Madison | A. T. Jones, Pendleton |
| Marion | Norman Beatty, Indianapolis |
| | E. F. Boggs, Indianapolis |
| | Bert E. Ellis, Indianapolis (Alternate) |
| | G. J. Garceau, Indianapolis |
| | E. V. Hahn, Indianapolis |
| | Harry L. Foreman, Indianapolis |
| | Marlow W. Manion, Indianapolis |
| | R. H. Moser, Indianapolis |
| | Harold C. Ochsner, Indianapolis |
| | J. O. Ritchey, Indianapolis |
| | Ernest Rupel, Indianapolis |
| | Russell A. Sage, Indianapolis |
| | J. M. Whitehead, Indianapolis |
| Monroe | William Karsell, Bloomington |
| Montgomery | G. A. Collett, Crawfordsville |
| Noble | C. E. Munk, Kendallville |
| Orange | C. E. Boyd, West Baden Springs |
| Parke-Vermillion | J. R. Bloomer, Rockville |
| Perry | N. A. James, Tell City |
| Pike | L. R. Miller, Winslow |
| Porter | John R. Frank, Valparaiso |
| Posey | J. R. Ranes, Mt. Vernon |
| Putnam | V. Earle Wiseman, Greencastle |
| Randolph | L. K. Phipps, Union City |
| Ripley | George S. Row, Osgood |
| Rush | C. C. Atkins, Rushville |
| St. Joseph | F. R. N. Carter, South Bend |
| | A. S. Giordano, South Bend |
| Shelby | W. D. Inlow Shelbyville |
| Sullivan | J. H. Crowder, Sullivan |
| Switzerland | L. H. Bear, Vevay |
| Tippecanoe | Gordon A. Thomas, Lafayette |
| | Earl Van Reed, Lafayette |
| Tipton | S. M. Cotton, Goldsmith |
| Vanderburgh | Minor Miller, Evansville |
| Vigo | E. O. Nay, Terre Haute |
| | M. C. Topping, Terre Haute |
| Wabash | O. G. Brubaker, North Manchester |
| Wayne-Union | Harry P. Ross, Richmond |
| | W. A. Thompson, Liberty |
| Wells | Harold Caylor, Bluffton |
| Whitley | Paul A. Garber, South Whitley |

### COUNCILORS

First District—I. C. Barclay, Evansville
Third District—A. P. Hauss, New Albany
Fifth District—A. M. Mitchell, Terre Haute
Sixth District—W. U. Kennedy, New Castle
Seventh District—Walter L. Portteus, Franklin
Eighth District—E. H. Clauser, Muncie
Ninth District—F. T. Romberger, Lafayette
Tenth District—William H. Howard, Hammond
Eleventh District—C. S. Black, Warren
Twelfth District—A. Jerome Sparks, Fort Wayne
Thirteenth District—Alfred Ellison, South Bend

### PAST PRESIDENTS

E. M. Shanklin, Hammond
Charles N. Combs, Terre Haute
George Daniels, Marion
F. S. Crockett, Lafayette
J. H. Weinstein, Terre Haute
E. E. Padgett, Indianapolis
R. L. Sensenich, South Bend
Herman M. Baker, Evansville
A. M. Mitchell, Terre Haute
J. T. Oliphant, Farmersburg

### OFFICERS

President—N. K. Forster, Hammond
President-elect—J. E. Ferrell, Fortville
Treasurer—A. F. Weyerbacher, Indianapolis
Executive Secretary—Thomas A. Hendricks
Assistant Executive Secretary—Ray E. Smith

### DELEGATE TO A. M. A.

Don F. Cameron, Fort Wayne

THE PRESIDENT: According to Chapter IV, Section 3, of the By-Laws, twenty delegates constitute a quorum. Doctor Amy, chairman of the Credentials Committee, informs me that there are more than twenty present, therefore the House of Delegates is declared open and ready for the transaction of business.

The By-Laws may be amended at any annual session by a *majority vote of all delegates present* at that session, after the amendment has laid on the table for one day. (Chapter XIV, Section 1, of By-Laws.)

The House of Delegates may amend any article of the Constitution by a *two-thirds vote of all delegates present* at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session and that it shall have been published twice during the year in THE JOURNAL of the Association. (Article XIV, Constitution.)

Any delegate who desires to speak must give his name and county so the reporter can get it.

Rising tribute will now be made in memory of those who were members of the House of Delegates, or who have served the state association in an official capacity and who have died since the 1944 annual session. The list follows:

JOHN A. ASPY, Indianapolis. Member of Committee on Public Policy and Legislation, 1934 and 1935.

D. A. BARTLEY, Indianapolis. Chairman of Section on Ophthalmology and Otolaryngology, 1938.

J. W. BAXTER, SR., New Albany. Secretary of Floyd County Medical Society, 1911 and 1912.

S. D. BEAVERS, Decatur. Secretary of Adams County Medical Society, 1916.

V. V. CAMERON, Marion. Secretary of Grant County Medical Society, 1910 to 1912, inclusive; First Vice-President, 1918; chairman of Medical Section, 1919; delegate from Grant county, 1934 and 1935.

R. M. COPELAND, Vevay. Secretary of Switzerland County Medical Society, 1912 to 1925, inclusive; 1934; and 1942 to 1944, inclusive.

E. M. CORBIN, Sullivan. Secretary of Sullivan County Medical Society, 1908.

JAMES M. DINNEN, Fort Wayne. Delegate to the American Medical Association, 1912 to 1914, inclusive.

G. G. ECKHART, Marion. Member of Committee on Scientific Work, 1916.

W. P. GARSHWILER, Indianapolis. Chairman of Committee on Prevention of Venereal Disease, 1910 and 1911; member of Committee on Vener-

eal Disease, 1913 and 1914; member of Committee on Scientific Exhibit, 1917; member of Committee on Arrangements, 1924; chairman of Public Relations Committee, 1933 to 1940, inclusive.

HARRY E. GRISHAW, Tipton. Member of Committee on Scientific Exhibit, 1918 and 1928; secretary of Tipton County Medical Society, 1929; delegate from Tipton County, 1936.

J. E. HANNA, Noblesville. Secretary of Hamilton County Medical Society, 1910 to 1913, inclusive.

MILTON T. JAY, Portland. Secretary of Jay County Medical Society, 1908 to 1912, inclusive.

E. C. MCDONALD, Indianapolis. Member of Committee on State Fair, 1936.

CLAUDE B. PAYNTER, Salem. Secretary of Washington County Medical Society, 1913 to 1916, inclusive; 1918 to 1920, inclusive; and 1929 to 1939, inclusive; member of Committee on Secretaries' Conference, 1934 and 1935; member of Medical Relief Committee, 1942 and 1943; secretary of Washington County Medical Society, 1943 and 1944; delegate from Washington County, 1934; 1937; 1940 to 1944, inclusive.

IRA E. PERRY, North Manchester. Councilor of Eleventh District 1928, 1929, 1930; and from July, 1935 to May, 1944; member of Committee on Credentials, 1930 and 1931; chairman of Study Committee on Aid to Needy Physicians, 1941 and 1942; member of Committee on Industrial Health, 1944; delegate from Wabash County, 1936.

R. H. RICHARDS, Patricksburg. Delegate from Owen County, 1943 and 1944.

A. E. SABIN, Dana. Secretary of Parke-Vermillion County Medical Society, 1942 and 1943.

L. E. SOMERS, Fort Wayne (formerly Monroe). Secretary of Adams County Medical Society, 1921.

W. N. THOMPSON, Sullivan. Member of Committee on Anesthesia, 1926.

H. H. WHEELER, Indianapolis. Member of Committee on Arrangements, 1924; vice-chairman of Surgical Section, 1926; member of Executive Committee, 1933 to 1936, inclusive.

BINE WHITLATCH, Milan. Secretary of Ripley County Medical Society, 1909 and 1910.

GEORGE T. WILLIAMS, Crawfordsville. Member of Committee on Necrology and History, 1944. Died in service:

MAJOR MICHAEL A. RAFFERTY, M.C., A. U. S., Elkhart. Killed in action in Belgium, November 24, 1944.

CAPTAIN ROBERT B. MILLER, M.C., A. U. S., Argos. Died on April 30, 1945, at the Percy Jones General and Convalescent Hospital, Battle Creek, Michigan, from injuries received in Germany.

LIEUT. WILLIAM VINCENT ECKHART, M.C., A. U. S., Marion. Killed in an automobile accident, May 17, 1945.

CAPTAIN CHARLES DOUGHERTY CLARK, M.C., A. U. S., South Bend. Killed April 28, 1945, as the result of a Japanese suicide plane attack, which crashed into the *U. S. Comfort*, naval hospital ship, fifty miles off Okinawa.

MAJOR GORDON H. HAGGARD, Hope. Listed missing October 7, 1944, in flight over Germany. Declared dead October, 1945.

(On motion of Dr. Daniels, duly seconded, the minutes of the previous meetings, as published in THE JOURNAL, were accepted.)

(The president asked if there were any eminent guests present, and, if so, for the members who knew them to introduce them. There being none, the meeting proceeded.)

THE PRESIDENT: Article V of the Constitution gives the A. M. A. delegates the right to sit in the House of Delegates, have the privilege of the floor, but no power to vote. This has been interpreted to include alternates also.)

| *Delegates* | *Alternates* |
|---|---|
| Don F. Cameron, Fort Wayne | N. M. Beatty, Indianapolis |
| F. S. Crockett, Lafayette | A. M. Mitchell, Terre Haute |
| H. G. Hamer, Indianapolis | K. R. Ruddell, Indianapolis |
| George R. Dillinger, French Lick | A. S. Giordano, South Bend |

*All members of the association* who desire to sit in on this meeting to hear the deliberations of the House are welcome.

In accordance with Chapter IX, Section 1, of the By-Laws of the association, reference committees have been appointed by the president, and were published in the October JOURNAL and in the *Handbook*. These committees are to serve during the session at which they are appointed.

*These reference committees should not be confused with the all-year-round standing committees.* To these committees shall be referred all reports, resolutions, and measures presented to the House of Delegates at this session, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted at the *last* meeting of the House of Delegates (Thursday, November 8, 7:00 A. M.) for acceptance in the original or modified form, or for rejection. The Thursday morning breakfast meeting will be held in the West Dining Room of the French Lick Springs Hotel.

Each committee consists of five members, the first member named to be chairman of the committee.

As these committees are named, kindly rise and remain standing, so that you may be recognized among yourselves and among the delegates, and as soon as your committee announcement has been made, will you kindly congregate in some spot in the hall, to determine the time and place of your meeting, so that it may be announced by the chair, that all may know it and appear before this committee in case they desire to do so.

## REFERENCE COMMITTEES

**1945**

**1. SECTIONS AND SECTION WORK**
C. P. Fox, Washington (Daviess-Martin), Chairman.
G. S. Fessler, Rising Sun (Dearborn-Ohio).
I. M. Sanders, Greensburg (Decatur).
Carl Clark, Oakland City (Gibson).
A. T. Jones, Pendleton (Madison).

**2. RULES AND ORDER OF BUSINESS**
C. R. Pettibone, Crown Point (Lake) Chairman.
William Wright, Fort Wayne (Allen).
S. M. Cotton, Goldsmith (Tipton).
Will A. Thompson, Liberty (Wayne-Union).
Herman M. Baker, Evansville (Vanderburgh).

**3. MEDICAL EDUCATION AND HOSPITALS**
Marlow W. Manion, Indianapolis (Marion) Chairman.
Harold D. Caylor, Bluffton (Wells).
C. M. Sennett, South Bend (St. Joseph).
V. Earle Wiseman, Greencastle (Putnam).
Paul A. Garber, South Whitley (Whitley).

**4. PUBLIC POLICY AND LEGISLATION**
H. W. Eggers, Hammond (Lake) Chairman.
E. Vernon Hahn, Indianapolis (Marion).
F. M. Lynn, Peru (Miami).
C. E. Briscoe, New Albany (Floyd).
E. O. Nay, Terre Haute (Vigo).

**5. PUBLICITY**
Gordon A. Thomas, Lafayette (Tippecanoe) Chairman.
J. H. Barrow, Dale (Spencer).
John R. Frank, Valparaiso (Porter).
L. R. Miller, Winslow (Pike).
Ralph W. Lochry, Indianapolis (Marion).

**6. HYGIENE AND PUBLIC HEALTH**
J. O. Ritchey, Indianapolis (Marion) Chairman.
R. J. Harvey, Zionsville (Boone).
Clay A. Ball, Muncie (Delaware-Blackford).
C. M. Donahue, Carmel (Hamilton).
E. R. Clarke, Kokomo (Howard).

**7. AMENDMENTS TO CONSTITUTION AND BY-LAWS**
J. H. Weinstein, Terre Haute (Vigo) Chairman.
M. B. Catlett, Fort Wayne (Allen).
Max Adams, Flora (Carroll).
C. E. Canaday, New Castle (Henry).
J. T. Carney, Jeffersonville (Clark).

**8. REPORTS OF OFFICERS**
G. A. Collett, Crawfordsville (Montgomery) Chairman.
P. Q. Row, Hammond (Lake).
Harry P. Ross, Richmond (Wayne-Union).
F. R. N. Carter, South Bend (St. Joseph).
R. C. Beeler, Indianapolis (Marion).

**9. COMMITTEE ON CREDENTIALS**
A. E. Stinson, Rochester (Fulton) Chairman.
Rollin Moser, Indianapolis (Marion).
N. A. James, Tell City (Perry).
Jon N. Kelly, LaPorte (LaPorte).
J. Frank Maurer, Brazil (Clay).

**10. COMMITTEE ON MISCELLANEOUS BUSINESS**
M. R. Lohman, Fort Wayne (Allen) Chairman.
E. B. Jewell, Logansport (Cass).
A. C. Yoder, Goshen (Elkhart).
F. B. Mountain, Connersville (Fayette-Franklin).
K. L. Hull, Bloomfield (Greene).

These reference committees should organize immediately after the adjournment of the House today. Time will be given at the conclusion of this meeting for the chairman of each reference committee to announce on the floor of the House the time and place his committee is to meet. Each reference committee chairman, at the conclusion of this meeting, should turn over to the executive secretary a memorandum giving the time and place of his committee meeting in order that this information may be placed on the bulletin board at the registration desk.

Miss Kribs will be available at the headquarters' desk in the Exhibit Hall, on the north porch, to type reports of the reference committees, and all chairmen should have their reports typed before the last meeting of the House of Delegates.

Next we come to the Reports of Officers: (1) Address of the President. This address will be referred to the Reference Committee on Reports of Officers, with the exception of one paragraph, which has to do with an annual registration fee, which paragraph is referred to the Reference Committee on Public Policy & Legislation.

We are now privileged to hear the address of the president-elect:

### ADDRESS OF THE PRESIDENT-ELECT

DR. J. E. FERRELL:

Mr. Chairman, Members of the House of Delegates:

I do not have a prepared address, because I have been ill since June eleventh. I have not been able to prepare an address, but if you will excuse me this time I will try to do better next year.

THE PRESIDENT: Thank you, Dr. Ferrell.

### REPORT OF EXECUTIVE SECRETARY

Referred to the Reference Committee on Reports of Officers.

### REPORT OF TREASURER

Referred to Reference Committee on Reports of Officers.

### REPORT OF CHAIRMAN OF COUNCIL

DR. ROMBERGER: The Chairman of the Council wishes to make the following addendum to the Report, a transaction which took place this morning at our Council meeting:

> "The Council recommends to the House of Delegates that the $5.00 War Assessment paid in 1945 be continued for 1946, and then terminated."

In clarification of the War Assessment, the situation with regard to dues of those of our profession who served in the armed forces, the Council took the following action, which is merely explanatory:

> "Medical officers discharged after January 1, 1946, do not pay 1946 dues. No officer who has served in the armed forces shall be assessed the $5.00 special assessment—date of expiration of terminal leave to be determining date."

Report of the Chairman of the Council and the additional report referred to Reference Committee on Reports of Officers.

## REPORTS OF STANDING AND SPECIAL COMMITTEES

### COMMITTEE ON CREDENTIALS

Referred to Reference Committee on Credentials.

### EXECUTIVE COMMITTEE

Referred to Reference Commitee on Reports of Officers.

COMMITTEE ON ARRANGEMENTS

Verbal statement referred to Reference Committee on Miscellaneous Business.

COMMITTEE ON SCIENTIFIC WORK

Referred to Reference Committee on Sections and Section Work.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Referred to Reference Committee on Public Policy and Legislation.

BUREAU OF PUBLICITY

Referred to Reference Committee on Publicity.

COMMITTEE ON CIVIC AND INDUSTRIAL RELATIONS

Referred to Reference Committee on Public Policy and Legislation.

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

Referred to Reference Committee on Medical Education and Hospitals.

COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS

Referred to Reference Committee on Public Policy and Legislation.

JOURNAL PUBLICATION COMMITTEE

Referred to Reference Committee on Reports of Officers.

SECRETARIES' CONFERENCE

Referred to Reference Committee on Miscellaneous Business.

COMMITTEE ON PREPAYMENT OF MEDICAL AND SURGICAL CARE

To be discussed at special meeting of House of Delegates.

NECROLOGY

Referred to Reference Committee on Miscellaneous Business.

PHYSICAL FITNESS

Referred to Reference Committee on Hygiene and Public Health.

MENTAL HEALTH

Referred to Reference Committee on Hygiene and Public Health.

STUDY OF LAY ACTIVITY IN MEDICAL PRACTICE

Dr. W. D. Gatch: I have been requested to make this addition to the report, and I feel that the members of the committee will approve of it. It is by request of the Wayne County Medical Society (Detroit, Michigan). They request that the House of Delegates instruct our delegates to the A.M.A. to advocate a Section on General Practice.

(Referred to Reference Committee on Public Policy and Legislation.)

ADVISORY COMMITTEE TO THE BUREAU OF MATERNAL AND CHILD HEALTH OF THE INDIANA STATE BOARD OF HEALTH

Referred to Reference Committee on Public Policy and Legislation.

LIAISON COMMITTEE OF THE DIVISION OF SERVICES FOR CRIPPLED CHILDREN

Referred to Reference Committee on Public Policy and Legislation.

AUDITING COMMITTEE

Referred to the Council.

CONTROL OF CANCER

Referred to Reference Committee on Hygiene and Public Health.

VENEREAL DISEASE

Referred to Reference Committee on Hygiene and Public Health.

INDUSTRIAL HEALTH

Referred to Reference Committee on Hygiene and Public Health.

COMMITTEE ON INDIANA INTER-PROFESSIONAL HEALTH COUNCIL

Referred to Reference Committee on Miscellaneous Business.

ANTI-TUBERCULOSIS COMMITTEE

Referred to Reference Committee on Hygiene and Public Health.

CONSERVATION OF VISION

Referred to Reference Committee on Hygiene and Public Health.

WAR PARTICIPATION

Referred to Reference Committee on Miscellaneous Business.

PHYSICAL THERAPY

Referred to Reference Committee on Public Policy and Legislation.

MEDICAL RELIEF

Referred to Reference Committee on Public Policy and Legislation.

RURAL MEDICAL CARE

Referred to Reference Committee on Public Policy and Legislation.

OPA MEDICAL ADVISORY COMMITTEE

Referred to Reference Committee on Hygiene and Public Health.

HARD OF HEARING

Referred to Reference Committee on Hygiene and Public Health.

POSTWAR MEDICAL SERVICE

Dr. John D. Van Nuys: I have a brief report, Mr. President. The activities of the Committee on Postwar Medical Service have been confined to the latter part of the year, because our problems arose after the termination of the war in Europe. The first meeting was held in July, and the last on October 17.

"REPORT OF COMMITTEE ON POSTWAR MEDICAL SERVICE, INDIANA STATE MEDICAL ASSOCIATION

"The Committee on Postwar Medical Service in submitting this report is mindful of the many urgent problems confronting the House of Delegates of the Indiana State Medical Association in this critical post-war period. It is firm in its belief, however, that no more pressing problem confronts the membership than that of the orderly assimilation into civilian practice of the medical veterans of World War II. Already a substantial number of the more than 1200 Indiana physicians serving in the armed forces have been released from military duty, and have returned to us to pursue postgraduate study, enter on residency appointments, or enter private practice. Their individual problems are many and varied. Through correspondence and personal interviews the committee has been able to assist many veterans in securing matriculation into postgraduate courses, obtaining residency appointments, obtaining benefits under the G.I. Bill of Rights, and securing information for them regarding full-time positions and locations for practice. It is becoming increasingly clear that such a service from the state office alone will not be adequate. The responsibility for personal service to the returned veteran in obtaining office space and living accommodations for himself and family will necessarily fall on the membership of the county societies. Some of the counties of the state have already appointed post-war medical service committees. Other societies may follow this plan, or place these responsibilities on the officers of the association.

"During the past year the State Committee on Postwar Medical Service has done the following:

1. Completed a survey of the entire state in compliance with the request of the American Medical Association in determining locations, number of physicians, hospital facilities, and economic conditions in each county in Indiana. This tabulated information is at the disposal of any member of the Medical Association by communicating with the Bureau of Information at the state headquarters' office.

2. Joined with the Executive Committee of the State Medical Association in establishing a Bureau of Information at the state headquarters' office, which can supply information on postgraduate studies, residencies, veterans' affairs, locations, et cetera.

3. Has been in communication with hospitals and teaching centers of Indiana and surrounding states, and can supply veterans with information on postgraduate instruction.

4. Has ascertained from the United States Veterans' Bureau all information pertaining to rights and privileges under the G.I. Bill of Rights.

"The Committee wishes to emphasize that while many veterans have problems that are similar confronting them on their return from military service, the solution of these problems in most instances can only be achieved on an individual case basis. We ask that the veterans be encouraged to bring their problems to us. We shall give each case individual attention and do our best to solve the problem ourselves, or enlist the aid of those who can be of assistance. We shall do our best to make adjustments promptly, but we also ask that we be given sufficient time in each case to make an intelligent analysis of the problem and to approach the solution in a satisfactory manner. The satisfactory end result of these activities can only be gained by teamwork and the full cooperation of every active member of the medical association. We feel certain that such cooperation and support will be forthcoming to the committee in its continuation and successful completion of the important work now in progress.

John D. Van Nuys, M. D., *Chairman*,
W. C. Wright, M.D.,
O. R. Spigler, M.D.,
Paul W. Ferry, M.D.,
R. N. Bills, M.D.,
Wm. R. Davidson, M.D.,
Robert V. Hoffman, M.D.,
S. T. Miller, M.D.,
R. W. Lavengood, M.D."

There is a meeting scheduled for one o'clock tomorrow, immediately following the luncheon, at which time veterans will be given an opportunity to express themselves. I am sure the entire membership of the association will be interested in attending this session. I feel that it is a problem that is before all of us, and to have this orderly assimilation is extremely important.

The President: Everyone is invited to the luncheon, but the meeting following it is confined to those in uniform or those lately discharged.

MEDICAL ECONOMICS

Referred to Reference Committee on Miscellaneous Business.

COMMITTEE ON REHABILITATION SERVICES

Referred to Reference Committee on Miscellaneous Business.

CENTENNIAL CELEBRATION

Referred to Reference Committee on Publicity.

SCIENTIFIC EXHIBIT

Referred to Reference Committee on Sections and Section Work.

REPORT OF DELEGATES TO A. M. A.

(There being no report, nothing was referred.)

The President: Communications that have been received during the year have been referred to the various standing committees or the Council, and have been disposed of. This indicates active, working committees.

Mr. Hendricks: Here is a letter from Dr. H. C. Wadsworth, Washington, dated October 9, 1945:

"A resignation and a request.

"My illness of four years has me down—vertigo and general muscular weakness. I cannot be at the French Lick meeting November 6.

"This is my resignation of all dignities and powers as councilor of the Second District of the Indiana Medical Association.

"The councilor to succeed me will be named by the delegates of the constituent counties. He will serve for the years 46-47-48. Will you please see that he is delegated to attend the Council meetings of November 6th and 8th, '45; vacancy resulting from my resignation?

"It had been my hope to finish fifteen years as councilor, but it was not 'in the cards.'

"It is with agreeable memories that I look back upon my fifteen years of association with you. An old shepherd with years of herding a large, timid, forgetful, selfish, changeable, frightened, stampeding herd of mixed-breed Rams has had nothing on you and your job. Indiana Medical Association needs you. Look out for them. But, look out for yourself."

THE PRESIDENT: Inasmuch as this entails the appointment of a new councilor to finish out Dr. Wadsworth's term, I will ask the delegates representing the counties of the Second District if they have arrived at any conclusion in regard to a councilor.

DR. OLIPHANT: We have had no meeting of the delegates of the Second District, as far as I know.

(The president asked that the delegates from the Second District retire, discuss this, and report back when the meeting came to the heading of new business.)

MR. HENDRICKS: Following is a letter from Dr. George R. Dillinger, Thomasville, Georgia, dated November 1, 1945:

"The House of Delegates,
Indiana State Medical Association.
Gentlemen:

"It is with the deepest regret that I send in my resignation as your delegate to the American Medical Association.

"I cannot express to you the deep appreciation that I have of your confidence in me as evidenced by the fact that you have repeatedly elected me to this position.

"I hope that you will continue to make the cause of the men who are doing the general practice of medicine one of the most important problems for your consideration. It is believed by many that a Specialty Board for general practice should be established, so that the general practitioner may have suitable recognition in his field of work.

"Again, let me express my deep appreciation for your confidence, and it is with sadness that I extend this resignation to you."

THE PRESIDENT: In the event of the resignation of a Delegate to the A.M.A., the precedent has been that the alternate assumes the rest of the term, and inasmuch as Dr. Dillinger has two more years to serve, Dr. Giordano is eligible to succeed him. Is it the wish of the House that Dr. Giordano succeed Dr. Dillinger? (Such a motion was made, duly seconded, and carried.)

DR. ROSS: Is it in order to make a suggestion about the alternate to Dr. Giordano at this time?

THE PRESIDENT: At the second meeting on Thursday morning there will be an election of one or two delegates to the A.M.A., and I think that would be the time and place to bring that matter up.

Any memorials to be presented? (None.) Any resolutions?

DR. TOPPING (Vigo County): I have the following resolution:

"WHEREAS, It is the desire of the members of the Indiana State Medical Association to be of every possible assistance to veterans of World War II in returning to civil life and there are many who, by reason of being physically handicapped through service-connected injuries and diseases, may be regarded hazardous and undesirable employees under the penalties of existing laws, such that they might find great difficulty in securing employment in industry,

"THEREFORE, BE IT RESOLVED, That such legislation should be enacted by the General Assembly of Indiana as will permit employers in industry to employ physically-handicapped persons under all effective laws, with proper relief to the employees for injuries and diseases and the results of such injuries and diseases arising directly from a particular employment, but with credit thereon to the employers for injuries and diseases, and the result of such injuries and diseases which the employees may have previously suffered.

Respectfully submitted,

NORMAN M. BEATTY, M.D.,
J. WM. WRIGHT, M.D.,
*Co-Chairmen*,
GEORGE DANIELS, M.D.,
JOHN HEWITT, M.D.,
J. R. DOTY, M.D.,
M. R. LOHMAN, M.D.,
J. S. NIBLICK, M.D.,
WALTER F. KELLY, M.D.,
ROBERT ACRE, M.D."

(Referred to the Reference Committee on Public Policy and Legislation.)

DR. GARBER (Whitley County):

"WHEREAS, the Indiana State Medical Association's activities have increased to such an extent that they should be considering the advisability of building a permanent home, and

"WHEREAS, the Indianapolis Medical Society is making plans at present to build a permanent home,

"BE IT RESOLVED, That a committee, to be known as the Building Committee of the Indiana State Medical Association, be appointed. This committee shall be instructed to confer with the

Building Committee of the Indianapolis Medical Society, in order that a building may be built which will fill the needs of both the Indianapolis Medical Society and State Medical Association.

"FURTHER, BE IT RESOLVED, If satisfactory arrangements can be made with the Indianapolis Medical Society, the Council of the Indiana State Medical Association shall be instructed to proceed with plans for raising funds to finance the State Association's share in the project. The Building Committee shall supervise the planning of such a building."

(Referred to the Reference Committee on Miscellaneous Business.)

Dr. Gordon Thomas read a three-page mimeographed report at this point, entitled "The Board (Proposed) of the General Practice of Medicine":

THE BOARD (PROPOSED) OF THE GENERAL PRACTICE OF MEDICINE

*Purpose:*

1. To encourage the study, improve the practice, and elevate the standards of the General Practice of Medicine.

2. To determine the competence of those practitioners who desire special recognition.

3. To arrange, control, and conduct examinations to test the qualifications of the general practitioners desiring certification.

4. To grant and issue certificates of qualification to candidates successful in demonstrating their proficiency.

5. To serve the public, hospitals, and medical schools. We believe that no valid argument can be made against the claim that the best, and certainly the cheapest medical care, is that given by a competent general practitioner. He has the affection and confidence of his patients. He knows their family background, personal traits, vices, and virtues.

6. To attract the ablest men to the general practice of medicine. We believe there is an unhealthy growth of specialism at the expense of the general practice, due to able men drifting into specialties.

7. To better enable the general practitioner to recognize conditions that require the services of a specialist.

*Value:*

Each certificate granted does not, of itself, confer upon any person any degree or legal qualifications, privileges, or license. Neither does the Board intend, in any way, to interfere with the professional activities of any duly-licensed physician.

It is anticipated that the certificate will become of value in the medical and hospital circles, and to the lay public.

*Revocations:*

If the physician so certified shall violate the standards of the ethical practice of medicine, or his license to practice medicine shall be revoked or suspended, or if he is expelled from his county society, then his certificate will be immediately revoked.

*Preliminary Requirements:*

1. A high ethical and professional standing.

2. A membership in the American Medical Association.

3. Graduate of a Class-A medical school.

4. One-year general rotating intern service in a recognized hospital. A second-year general internship or mixed residency is to be considered as a year of practice.

5. A citizen of the U.S.A.

6. Continues his postgraduate training.

7. A minimum of eight years of general practice after completion of a year of internship.

*Principals of Training:*

The Board of General Practice does not propose to establish fixed rules for the training of candidates for certification in this field. Broad, general principles for training, however, may be outlined, although such suggestions as are made must of necessity be subject to constant changes reflecting the trend of advances in the medical profession.

1. A sound knowledge of physiology, biochemistry, pharmacology, anatomy, bacteriology, and pathology in-so-far as they apply to disease is essential for continued progress of the individual who practices general medicine. Such knowledge may be obtained in a number of ways:
   (a) By properly arranged and supervised graduate courses.
   (b) By the opportunities for study afforded by the appointment of physiology, biochemistry, pathology, etc., with attendance upon advanced lectures in the other subjects.
   (c) By advanced study in these subjects while an intern or resident physician, and by the application of the principles involved to patients under one's control.
   (d) By the detailed study under supervision, of problems in which the physician brings the basic facts of physiology, pathology, etc., into direct relation with the concrete clinical problem. The analysis of a problem with detailed knowledge of its fundamental pathologic or physiologic background does much to stimulate thoroughness, clear thinking, and progress.

2. A portion of the written examination is designed to test the candidate's knowledge in these "pre-clinical" subjects, and especially in their application to disease rather than their purely laboratory aspects.

3. The mere factual knowledge of general medicine and its basic sciences is not sufficient. The candidate must have had training in their use in furthering his understanding in general medicine. This implies practical experience under the guidance of older men who bring to their problems ripe knowledge and critical judgment. Preparation to meet this requirement adequately may be even more difficult to obtain than the so-called scientific training.

4. The Board wishes to emphasize that time and training are but a means to the end of acquiring a

broadness and depth of knowledge of general medicine, which the candidate must demonstrate to the Board in order to justify it in certifying that he is competent to practice general medicine. The responsibility of acquiring the knowledge as best he may rests with the candidate, while the responsibility of maintaining the standard of knowledge required for certification devolves on the Board.

*Examinations:*

All applicants accepted for examination will be required to attain a passing grade in:

1. A review of case reports.
2. A written examination.
3. An oral clinical test.
4. Demonstration of ability at bedside and in laboratory.

Candidates who successfully complete one part may proceed to the next.

Whenever an applicant fails to pass the examination, the Board, upon request, will make suggestions as to suitable courses of instruction for the purpose of overcoming deficiencies in the applicant's knowledge.

*Part I:*

The candidate must file twenty-five case reports in condensed form of cases for which he was personally responsible. These reports must be sufficiently complete so the examiners can evaluate the judgment of the candidate in his choice of procedure.

They are to include a summary or analysis of each case with critical deductions derived from correctness or incorrectness of diagnosis and final results on discharge. This summary must include:

1. An account of the candidate's personal observation of the case.
2. The basis for diagnosis.
3. The facts that determined the course of treatment.
4. Critical conclusions to be drawn from the outcome of the case.

These case reports must also include a variety of material. It is suggested that they cover one or more of the following fields: infectious diseases, including venereal diseases; deficiency diseases; diseases of metabolism; gastro-intestinal tract; respiratory system; kidneys; blood-forming organs; circulatory system; glands of internal secretion; nervous system; bones, joints, and muscles; obstetrics; pediatrics; dermatology; neuropsychiatry; office gynecology; minor surgery; and allergy.

*Part II:*

A comprehensive written examination including questions of the basic medical sciences and subjects pertaining to the General Practice of Medicine.

*Part III:*

This part consists of an oral examination directed to ascertain the candidate's familiarity with recent medical literature, the breadth of his clinical experience, his capabilities, general adaptability, diplomacy, and his general qualifications.

*Part IV:*

Another part of the oral examination is conducted at the bedside and in the laboratory. Each candidate will be assigned one or more patients in the hospital.

(Referred to Reference Committee on Medical Education and Hospitals.)

### NEW BUSINESS

Dr. Sparks: Because of the increased amount of work that comes before the Council, the Council voted this morning to increase the number of regular meetings. In order to make this conform with our By-Laws, I offer the following amendment to our By-Laws:

"AMENDMENT TO BY-LAWS
CHAPTER VII—THE COUNCIL

"Section 1—The council shall meet as follows:

"1. Annually, in December or January. 2. On the day preceding the first day for the scientific meetings of the annual session of the Association. 3. On the last day of the annual session of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, et cetera, et cetera."

*Shall be changed to read as follows:*

"Section 1—The Council shall hold regular meetings as follows: 1. January, April, and July of each year. 2. On the day preceding the first day for the scientific meetings of the annual session of the Association. 3. On the last day of the annual session of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, et cetera, et cetera."

(Referred to the Reference Committee on Amendments to the Constitution and By-Laws.)

The President: We still have the matter of a Councilor from the Second District to discuss.

Dr. Oliphant: There are three delegates from the Second District, and there were three candidates for councilor, and we resorted to placing the names in a hat and drawing out the name of one. Dr. Crowder's name was drawn; I, therefore, present the name of Dr. James H. Crowder, of Sullivan, as councilor for the Second District.

The President: This is a little out of order, in that confirmation usually comes at the last meeting, but in order that the Second District may be represented I am going to ask if you will express your pleasure at this time as to whether or not you will accept the resignation of the delegate from the Second District, and that Dr. James H. Crowder be named as Delegate from that District. (Motion to that effect was made, duly seconded, and carried.)

A motion to adjourn was made, duly seconded, and carried, with the modification to the motion that the House would convene at 3:30 P.M. for a special meeting to consider the prepayment plans of medical insurance. Meeting adjourned at 2:45 P.M.

## INDIANA STATE MEDICAL ASSOCIATION

### HOUSE OF DELEGATES

**Special Meeting to Consider Report of Committee on Prepayment of Medical and Surgical Care, Main Convention Hall, French Lick Springs Hotel, Tuesday, November 6, 1945.**

Meeting called to order at 3:30 P.M.

The president, Dr. N. K. Forster, of Hammond, presided, and asked everyone present to sign attendance slips.

THE PRESIDENT: Will the chairmen of the Reference Committees who have not secured the resolutions referred to their committee come up and get them now? The resolution presented by Dr. Thomas for the Board of General Practitioners is taken from the Reference Committee on Miscellaneous Business and referred to the Committee on Medical Education and Hospitals. Will Dr. Manion kindly come up and get that resolution?

The chair will entertain a motion from some delegate that the attendance slips constitute the roll call for this meeting. (Motion made by Dr. Daniels, seconded by Dr. Oliphant, and carried.) These slips showed the following present:

#### DELEGATES

| *County* | *Delegates* |
|---|---|
| Adams | M. L. Habegger, Berne |
| Allen | M. B. Catlett, Fort Wayne |
| | M. R. Lohman, Fort Wayne |
| | Wm. C. Wright, Fort Wayne |
| | H. Vaughn Scott, Fort Wayne (Alternate) |
| Bartholomew | Lowell F. Beggs, Columbus |
| Boone | R. J. Harvey, Zionsville |
| Cass | E. B. Jewell, Logansport |
| Clark | J. T. Carney, Jeffersonville |
| Clay | J. F. Maurer, Brazil |
| Clinton | F. A. Beardsley, Frankfort |
| Daviess-Martin | C. P. Fox, Washington |
| Dearborn-Ohio | J. C. Elliott, Guilford (Alternate) |
| | M. J. McNeely, Dillsboro |
| Decatur | I. M. Sanders, Greensburg |
| Delaware-Blackford | Clay A. Ball, Muncie |
| | Bruce W. Stocking, Muncie |
| Dubois | S. L. McKinney, Huntingburg |
| Elkhart | A. C. Yoder, Goshen |
| Fayette-Franklin | E. M. Glaser, Brookville |
| | F. B. Mountain, Connersville |
| Floyd | C. E. Briscoe, New Albany |
| Fulton | A. E. Stinson, Rochester |
| Gibson | Carl Clark, Oakland City |
| Grant | R. W. Lavengood, Marion |
| Hamilton | R. F. Harris, Noblesville |
| Hancock | Joseph L. Allen, Greenfield |
| Hendricks | O. T. Scamahorn, Pittsboro |
| Henry | C. E. Canaday, New Castle |
| Huntington | G. M. Nie, Huntington |
| Jay | George Cring, Portland |
| Jennings | D. W. Matthews, North Vernon |
| Knox | C. L. Boyd, Vincennes |
| Lake | Henry W. Eggers, Hammond |
| | C. M. Jones, Whiting |
| | P. Q. Row, Hammond |
| | J. W. Iddings, Crown Point |
| | G. M. Young, Gary |
| Lawrence | Claude Dollens, Oolitic |
| Madison | A. T. Jones, Pendleton |
| Marion | Norman Beatty, Indianapolis (Alternate) |
| | E. F. Boggs, Indianapolis |
| | Bert E. Ellis, Indianapolis (Alternate) |
| | Harry L. Foreman, Indianapolis |
| | G. J. Garceau, Indianapolis |
| | E. V. Hahn, Indianapolis |
| | Marlow Manion, Indianapolis |
| | R. H. Moser, Indianapolis |
| | Harold C. Ochsner, Indianapolis |
| | J. O. Ritchey, Indianapolis |
| | Ernest Rupel, Indianapolis |
| | Russell Sage, Indianapolis |
| | B. F. Steele, Indianapolis (Alternate) |
| | J. M. Whitehead, Indianapolis |
| Marshall | A. A. Thompson, Tyner |
| Miami | J. E. Yarling, Peru |
| | S. D. Malouf, Peru (Alternate) |
| Monroe | William Karsell, Bloomington |
| Montgomery | G. A. Collett, Crawfordsville |
| Noble | C. E. Munk, Kendallville |
| Orange | C. E. Boyd, West Baden Springs |
| Owen | J. W. Thom, Spencer |
| Parke-Vermillion | J. R. Bloomer, Rockville |
| Pike | L. R. Miller, Winslow |
| Posey | J. R. Ranes, Mt. Vernon |
| Putnam | V. Earle Wiseman, Greencastle |
| Randolph | L. K. Phipps, Union City |
| Ripley | George S. Row, Osgood |
| Rush | C. C. Atkins, Rushville |
| St. Joseph | F. R. N. Carter, South Bend |
| | A. S. Giordano, South Bend |
| | C. M. Sennett, South Bend |
| Scott | M. L. McClain, Scottsburg |
| Shelby | W. D. Inlow, Shelbyville |
| Spencer | J. H. Barrow, Dale |
| Sullivan | J. H. Crowder, Sullivan |
| Switzerland | L. H. Bear, Vevay |
| Tippecanoe | Gordon A. Thomas, Lafayette |
| Tipton | S. M. Cotton, Goldsmith |
| Vanderburgh | Robert R. Acre, Evansville |
| | Minor Miller, Evansville |
| Vigo | Ernest O. Nay, Terre Haute |
| | M. C. Topping, Terre Haute |
| Wabash | O. G. Brubaker, North Manchester |
| Wayne-Union | Harry P. Ross, Richmond |
| | W. A. Thompson, Liberty |
| Wells | Harold Caylor, Bluffton |
| Whitley | Paul A. Garber, South Whitley |

#### COUNCILORS

First District—I. C. Barclay, Evansville
Third District—A. P. Hauss, New Albany
Fifth District—A. M. Mitchell, Terre Haute
Sixth District—W. U. Kennedy, New Castle
Seventh District—W. L. Portteus, Franklin
Eighth District—E. H. Clauser, Muncie
Ninth District—F. T. Romberger, Lafayette
Tenth District—W. H. Howard, Hammond
Eleventh District—C. S. Black, Warren
Twelfth District—A. Jerome Sparks, Fort Wayne
Thirteenth District—Alfred Ellison

#### PAST PRESIDENTS

Charles N. Combs, Terre Haute
George Daniels, Marion
Charles E. Gillespie, Seymour
F. S. Crockett, Lafayette
J. H. Weinstein, Terre Haute
E. E. Padgett, Indianapolis
R. L. Sensenich, South Bend
Herman M. Baker, Evansville
A. M. Mitchell, Terre Haute
C. H. McCaskey, Indianapolis
J. T. Oliphant, Farmersburg

**OFFICERS**

President.....N. K. Forster, Hammond
President-elect.....J. E. Ferrell, Fortville
Treasurer.....A. F. Weyerbacher, Indianapolis
Executive Secretary.....Thomas A. Hendricks
Assistant Executive Secretary.....Ray E. Smith

**DELEGATES TO A. M. A.**

D. F. Cameron, Fort Wayne

THE PRESIDENT: For the purpose of keeping the records straight, you understand that this meeting is a special, called meeting of the House of Delegates, authorized at the last meeting of the House of Delegates, on November 12, 1944, for the purpose of discussing the report of the Committee on Prepayment of Medical and Surgical Care, appointed by the then-president, Dr. Oliphant, with the advice and approval of the Council.

I will ask the Chairman of the Committee on Credentials if there is a quorum present. (Dr. Amy reported that there was.) This meeting is then declared open and ready for the transaction of business.

Before we begin our discussion I want to make an announcement in explanation of the rules which will govern this discussion. The chair will ask that each speaker endeavor to limit his discussion to not more than five minutes. Surely in that length of time you can present the essential points of your discussion. This is not an arbitrary rule, but a request in order to expedite the business of this meeting. The chair must ask, however, if anyone desires to speak more than once upon a question before the House that you ask for the consent of the House before you speak the second time. It is essential also that when you wish to speak on any question that you stand, announce your name and the county which you represent, or your office in the state organization. This is necessary in order that the reporter may secure an accurate record of the proceedings.

This being a special, called meeting of the House of Delegates to consider the plans recommended by the Committee on Prepayment of Medical and Surgical Care, no other business will be considered during this session.

In order to refresh the memories of some who may not have gone over the report of the Special Meeting held on November 12, 1944, permit me to state that the House of Delegates then passed the following motion:

1. That the Indiana State Medical Association approve a prepayment plan of health insurance.

2. That the Indiana State Medical Association approve an indemnity type of prepayment health insurance.

3. That the president, with the advice and approval of the Council, appoint a committee which is representative of physicians, both as to geographical distribution and as to the kinds of practice, to work out a plan to carry into effect the provisions of the motions adopted, which plans and provisions shall not be placed in operation until said completed plans and provisions and contracts are submitted to this House of Delegates for final approval or rejection.

4. That the president shall call a special session of the House of Delegates, to consider the plans of the committee here contemplated, when and if such plans are prepared and ready.

May I state that your wishes have been complied with, in that the committee, consisting of twenty-one members, representative as to geographical distribution and kinds of practice, was appointed by Dr. Oliphant, with the advice and approval of the Council. Dr. Walter U. Kennedy was named chairman, and this is the special called meeting to consider their report. Dr. Kennedy, are you ready to report?

DR. KENNEDY: Yes, sir.

"REPORT OF COMMITTEE ON PREPAYMENT OF MEDICAL AND SURGICAL CARE

"The committee has complied to the best of its ability with the instructions from the House of Delegates. It has studied all material it found available in the United States. It has written to all insurance companies interested in medical and surgical care insurance, of which it had any knowledge, for plan, rates, and expenses. It has checked over every plan in operation, known to the Federal Securities Commission, and has investigated the representative and larger plans. Many state plans were checked over in personal visits for first-hand information, and the Medical Care Committees of neighboring states were visited to learn their views.

"It being impracticable in so large a committee to expect each member to make the intensive and thorough examination and study of the advantages and disadvantages of each method, three sub-committees were formed, to whom access was given to all available data.

"At this time I desire to express my profound appreciation of the loyalty, sympathy, generous expenditure of time, real study, and intelligent consideration given to the matters assigned to them by these sub-committees. They deserve the thanks of the profession, not only in Indiana but nationally, for these reports are being sent for by State Medical Associations, and do truly represent the fullest study of medical insurance matters now available.

"To these Committees were assigned three types of plans: a medically-owned stock company; a regular lay insurance stock company; and a mutual service company. They were asked to lay aside every preconceived notion and belief, and to report findings of fact equally fair as to advantages and disadvantages. This, after many meetings, they did. Their reports carried not only their factual findings, but also their findings as to methods of carrying out the plan they were investigating, a sort of blue print or organization in event of that particular plan being adopted by the House of Delegates.

"Full copies of each sub-committee report were made and sent to each of the general committee

members. They thus had before them an array of factual conclusions covering every possible angle, such as no committee ordinarily has.

"The full committee met, heard the reports read by the sub-committee chairmen with their additional comments and special explanations. There was substantially no debating, everything having been fully covered. The committee then made its decision on the personal reaction of its members, and directed me, as chairman, to present its recommendation.

"It is assumed that each member of the House of Delegates has read all the reports of the subcommittees which were published in the October number of THE JOURNAL, and is as fully informed as were the committee members, or as they would be if the entire report were read now. Hence, it does not seem necessary or desirable to use two hours to read these reports.

"From all this research the question of insurance can be reduced to the consideration of a few facts. That there may be a clear understanding of the vital points involved, I shall briefly review these elementary facts.

"There are two basic principles, service and indemnity. The service plan was proposed to meet the needs of the social class immediately above the indigent class. It is a class which may be called the medically indigent, and for whom it is vociferously claimed that adequate medical care is not provided. They can get along without public assistance unless a medical emergency of the catastrophic type occurs. To many of them even a thorough examination with x-ray and laboratory work and hospitalization means a financial catastrophe.

"To this class, constituting a substantial part of our people, our sympathy is extended, and no decent-minded physician would ask or expect ordinary fees from them. But that they might save their self-respect and more freely apply for needed medical care, the service insurance plan was proposed.

"Essentially and basically it furnishes a complete attendance and service for each named illness or injury at a set fee, which is predetermined in a fee schedule and has no relation to the severity or length of the complaint. The physician agrees by actual or implied contract with the insurance company that no matter how severe or how long the illness, he will accept the stated fee as full compensation.

"It is a humanitarian plan for the poorer people in which the medical profession, in obedience to its ancient custom, serves the people at fees charged to be adequate for them. That the purpose of this plan be not defeated and misused by those able to compensate the physician more adequately and in accordance with the nature of the illness, the safeguard proposed is to limit the use of the plan to those of a low annual income, ordinarily $2,000 to $2,500, and to require additional compensation according to the individual case from those who have greater income. Unfortunately, for the medical profession, this limitation apparently cannot be enforced, and so far as I know no service plan now attempts to enforce these limits. The doctor must look out for his own interests.

"The indemnity plan has the same rates, the same schedule of fees, or indemnities as they are then called; but the indemnity paid is not intended to pay the whole charge unless the patient's circumstances make the indemnity a fair payment in full. Payment of the scheduled indemnity direct to the physician can be provided for in both plans.

"There is no fundamental practical difference between the results of the two plans if the service plan is restricted to those of low income by the rigid enforcement of entrance and eligibility limits, and by reviews of eligibility at proper intervals. The principal difference between the two methods is in the form of contract between the insuring company and the insured person. In the service plan, the patient makes a contract with the company and the company then makes a contract with the doctor. In the indemnity plan, the patient makes a contract with the company alone. There is no contract between the company and the doctor. None is needed, for the doctor deals directly with the patient. All service plans so far in operation are of the mutual type, in which each policyholder has equal ownership with all other policyholders, and the policyholders have the privilege of changing management or plans if such changes are asked and approved by a majority vote of the policyholders. Mutual companies may distribute their profits by increased privileges, or by lowering monthly charges, or by cash rebates on the fees collected.

"The indemnity plans may equally well be conducted by a mutual company. Or they may be conducted by a capital stock company in which the holders of the shares of stock are in permanent control, and may or may not receive dividends on the capital they hazard. A capital stock company may be one in which the capital required is wholly owned by a medical association or by physicians, or by a combination of both medical association and physicians, or by a purely lay organization, organized solely and specifically to carry on the business of insurance, whose capital stock may be owned by anyone who desires to invest in the company for profit or otherwise.

"The Indiana State Medical Association, as an association, could not carry on the business of insurance. But insurance in Indiana can be carried on only by corporations organized under the insurance laws for that purpose. The Medical Association was organized under a different law, and could not carry on insurance business under its charter.

"And now I shall proceed to the presentation of two resolutions, which as chairman of the committee on Prepayment of Medical and Surgical Care I believe it is my duty to present in order to bring the entire report of my committee before this House of Delegates for such action as may result in final disposition and settlement of the matters.

"First, by direction of my committee and as chairman thereof, in order to express as accurately as I can the prevailing vote of that committee, I move that the following resolution be adopted:

"RESOLVED, That the medical insurance plan shall be of the mutual medical service type."

THE PRESIDENT: Is there a second to this motion?

DR. SPARKS: I second the motion of Dr. Kennedy.

THE PRESIDENT: It has been moved and seconded that the medical insurance plan shall be of the mutual medical service type.

DR. G. M. NIE (Huntington): I am a member of this committee, and I am in general practice. Whereas the House of Delegates instructed this committee to recommend an indemnity type of insurance, I move that the report of the Committee on Prepayment of Medical and Surgical Care be amended as follows:

The words "mutual medical service plan" to be removed from the report and substituted by the words "an indemnity type of insurance." I offer this as an amendment.

(Seconded by Dr. Topping.)

THE PRESIDENT: It has been moved and seconded that the resolution of the Committee on Prepayment of Medical and Surgical Care be amended as follows:

The words "mutual medical service plan" be removed from the report and substituted by the words "an indemnity type of insurance."

Is there any discussion on that?

DR. HAUSS (Third District): I would like to offer an amendment to the resolution and amendment. I believe that this House of Delegates, which has been studying this for the past seven years, is now entitled to express its opinion. I believe that each and every individual here should be allowed to say now and for all time what they want, and what they think the Indiana State Medical Association should do.

There are four trends of thought, and I am very much surprised to see Dr. Nie, the one man who voted against the unanimous vote on the committee report, who got up and stated that he voted against it because he was not in favor of any plan, now comes out and offers a resolution for the indemnity plan. I say to you, I do not hold a brief for any plan of service. I have studied on this committee for two years, and I have tried to follow the mandates and the instructions of this House of Delegates of expressing our opinion of what is best on the subject.

Now, Mr. President, in order to clarify this subject for all time, I offer a resolution that does not say that we shall vote for one plan and allow the other three groups to vote against it, but that we vote on all four trends of thought, the mutual indemnity, the commercial indemnity, the mutual service plan, and the group who are actually and absolutely against any action toward insurance may be given an opportunity to express their vote. So I offer this resolution:

"WHEREAS, The Indiana State Medical Association, its House of Delegates, and its Reference and Study Committees have studied and considered the subject of prepayment of medical care for several years, and

"WHEREAS, Three distinct plans of sponsored medical care insurance have been under consideration, namely, the Mutual Non-Profit Indemnity Plan, the Commercial Indemnity Plan, and the Mutual Non-Profit Medical Service Plan, and

"WHEREAS, There are in the membership of this House of Delegates sincere advocates of each of these plans, and

"WHEREAS, There is a fourth group in this association which opposes the sponsoring or adoption of any plan of medical insurance,

"THEREFORE, BE IT RESOLVED, That this House of Delegates cast a roll call vote permitting each delegate to state which of the four plans he prefers, and

"BE IT FURTHER RESOLVED, That this balloting be continued until the desire of the House of Delegates is expressed by a majority vote."

I offer that as an amendment to the amendment on the resolution.

THE PRESIDENT: There is a question of order on this resolution, and that has to do with whether it is an amendment to the amendment, or whether he wishes to present it as a substitute for the amendment originally presented.

MR. STUMP: I think as a point of order your resolution should not be submitted as an amendment to the amendment. It should read, "I move to substitute the following resolution for the original resolution presented."

DR. HAUSS: That was my idea, and I so move that it be offered in place of the original motion.

DR. DANIELS (Marion): I wish to move in favor of this matter that is being considered by Dr. Hauss.

THE PRESIDENT: Inasmuch as the substitute resolution presented by Dr. Hauss has not been seconded, it is lost.

The question before the House is on the amendment to the original motion that the words "mutual medical service plan" be removed from the report and substituted by the words "an indemnity type of insurance." Is there any discussion?

DR. BEGGS (Columbus): Does that mean a mutual plan or a commercial indemnity plan?

THE PRESIDENT: It does not state. It simply says, "indemnity type of insurance."

The question before the House is that the motion that the medical insurance plan shall be of the mutual medical service type shall be amended, and that the words "mutual service plan" be removed from the report and substituted by the words "an indemnity type of insurance." As many as are in favor of this will say, "Aye"; opposed "No."

The "Ayes" have it, and the amendment is carried.

The question now before the House is on the original motion, the original motion as amended, which is that the medical insurance plan shall be of the indemnity type of insurance. Is there any

discussion? As many as are in favor will say "Aye"; opposed "No." The "Ayes" have it and the motion is carried.

DR. KENNEDY:

"Acting further as chairman of the committee, and for the purpose of completion of the disposition of the matters intrusted to this committee in a manner consonant with the committee's expressed views, I now move the following resolution be adopted:

"RESOLVED, That the Council of the Indiana State Medical Association be authorized and directed to carry out the directive resolution just adopted, or which may hereafter be adopted, by the House of Delegates, concerning medical insurance."

THE PRESIDENT: Is there a second? (Duly seconded.) It has been moved and seconded that the Council of the Indiana State Medical Association be authorized and directed to carry out the directive resolution just adopted, or which may hereafter be adopted, by the House of Delegates, concerning medical insurance. Is there any discussion?

Resolved, that the Council of the Indiana State Medical Association be authorized and directed to carry out the directive resolution just adopted, or which may hereafter be adopted, by the House of Delegates, concerning medical insurance." As many as are in favor, say "Aye"; opposed "No." The "Ayes" have it, and the motion is carried.

If there are no further recommendations, a motion to adjourn is in order.

(Moved, seconded, and carried for adjournment.)

The next meeting of the House of Delegates will be held Thursday morning.

(Meeting adjourned at 4:15 P. M.)

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## INDIANA STATE MEDICAL ASSOCIATION

### HOUSE OF DELEGATES

*(French Lick Session, 1945)*

#### Second Meeting

The second meeting of the House of Delegates, a breakfast meeting, was held Thursday, November 8, 1945, in the West Room, French Lick Springs Hotel, convening at 8:00 o'clock; the president, Dr. N. K. Forster, presiding.

THE PRESIDENT: The Reference Committee on Credentials has designated that Dr. Weyerbacher call the roll. Roll call showed the following members present:

DELEGATES

| *County* | *Delegates* |
|---|---|
| Allen | M. B. Catlett, Fort Wayne |
| | Arnold H. Duemling, Fort Wayne |
| | Wm. C. Wright, Fort Wayne |
| | M. R. Lohman, Fort Wayne |
| Bartholomew | Lowell F. Beggs, Columbus |
| Carroll | Max R. Adams, Flora |
| Cass | E. B. Jewell, Logansport |
| Clark | J. T. Carney, Jeffersonville |
| Clay | J. F. Maurer, Brazil |
| Daviess-Martin | C. P. Fox, Washington |
| Decatur | I. M. Sanders, Greensburg |
| Delaware-Blackford | Clay A. Ball, Muncie |
| | Bruce Stocking, Muncie |
| Dubois | S. L. McKinney, Huntingburg |
| Elkhart | A. C. Yoder, Elkhart |
| Fayette-Franklin | E. M. Glaser, Brookville |
| | F. B. Mountain, Connersville |
| Floyd | C. E. Briscoe, New Albany |
| Fulton | A. E. Stinson, Rochester |
| Gibson | C. M. Clark, Oakland City |
| Grant | R. W. Lavengood, Marion |
| Hamilton | Robert F. Harris, Noblesville |
| Hancock | Joseph L. Allen, Greenfield |
| Harrison | William E. Amy, Corydon |
| Hendricks | O. T. Scamahorn, Pittsboro |
| Howard | E. R. Clarke, Kokomo |
| Huntington | G. M. Nie, Huntington |
| Jackson | L. H. Osterman, Seymour |
| Jasper-Newton | W. G. Pippenger, Brook |
| Jay | George Cring, Portland |
| Johnson | Oran Province, Franklin |
| Lake | P. Q. Row, Hammond |
| | H. W. Eggers, Hammond |
| | James G. Shanklin, Hammond (Alternate) |
| | T. J. Senese, Gary (Alternate) |
| | G. L. Verplank, Gary |
| Lawrence | Claude Dollens, Oolitic |
| Madison | A. T. Jones, Pendleton |
| Marion | J. M. Whitehead, Indianapolis |
| | Marlow W. Manion, Indianapolis |
| | Cleon A. Nafe, Indianapolis |
| | Harry L. Foreman, Indianapolis |
| | Ernest Rupel, Indianapolis |
| | E. V. Hahn, Indianapolis |
| | B. E. Ellis, Indianapolis |
| | G. J. Garceau, Indianapolis |
| | H. C. Ochsner, Indianapolis |
| | Norman Beatty, Indianapolis (Alternate) |
| | R. H. Moser, Indianapolis |
| | J. O. Ritchey, Indianapolis |
| | R. V. Myers, Indianapolis |
| | E. F. Boggs, Indianapolis |
| | Brandt F. Steele, Indianapolis (Alternate) |
| Marshall | A. A. Thompson, Tyner |
| Miami | F. M. Lynn, Peru |
| | S. D. Malouf, Peru (Alternate) |
| Monroe | William A. Karsell, Bloomington |
| Montgomery | G. A. Collett, Crawfordsville |
| Noble | C. E. Munk, Kendallville |
| Orange | C. E. Boyd, West Baden Springs |
| Owen | J. W. Thom, Spencer |
| Parke-Vermillion | S. C. Darroch, Cayuga |
| Pike | L. R. Miller, Winslow |
| Porter | John R. Frank, Valparaiso |
| Putnam | V. Earle Wiseman, Greencastle |
| Ripley | George S. Row, Osgood |
| Rush | C. C. Atkins, Rushville |
| St. Joseph | A. S. Giordano, South Bend |
| | F. R. N. Carter, South Bend |
| Scott | M. L. McClain, Scottsburg |
| Shelby | W. D. Inlow, Shelbyville |
| Tippecanoe | Earl Van Reed, Lafayette |
| | Gordon A. Thomas, Lafayette |
| Vanderburgh | Minor Miller, Evansville |
| | Robert R. Acre, Evansville |
| Vigo | M. C. Topping, Terre Haute |
| | E. O. Nay, Terre Haute |
| Wabash | O. G. Brubaker, North Manchester |
| Wayne-Union | Harry P. Ross, Richmond |
| | W. A. Thompson, Liberty |
| Wells | Harold Caylor, Bluffton |
| Whitley | Paul A. Garber, South Whitley |

### COUNCILORS

First District—I. C. Barclay, Evansville
Second District—J. H. Crowder, Sullivan
Third District—A. P. Hauss, New Albany
Sixth District—W. U. Kennedy, New Castle
Seventh District—W. L. Portteus, Franklin
Eighth District—E. H. Clauser, Muncie
Tenth District—W. H. Howard, Hammond
Eleventh District—C. S. Black, Warren
Twelfth District—A. Jerome Sparks, Fort Wayne
Thirteenth District—Alfred Ellison, South Bend

### PAST PRESIDENTS

W. R. Davidson, Evansville
E. M. Shanklin, Hammond
Charles N. Combs, Terre Haute
George Daniels, Marion
F. S. Crockett, Lafayette
J. H. Weinstein, Terre Haute
R. L. Sensenich, South Bend
E. M. Van Buskirk, Fort Wayne
Karl Ruddell, Indianapolis
A. M. Mitchell, Terre Haute
M. A. Austin, Anderson
C. H. McCaskey, Indianapolis
J. T. Oliphant, Farmersburg

### OFFICERS

President—N. K. Forster, Hammond
President-elect—J. E. Ferrell, Fortville
Treasurer—A. F. Weyerbacher, Indianapolis
Executive Secretary—Thomas A. Hendricks
Assistant Executive Secretary—Ray E. Smith
Attorney—Albert Stump

### DELEGATE TO A. M. A.

D. F. Cameron, Fort Wayne

### ELECTION OF OFFICERS

Election of officers resulted as follows:

| | |
|---|---|
| President-elect: | Floyd T. Romberger, Lafayette. |
| Treasurer: | A. F. Weyerbacher, Indianapolis. |
| Delegates to A.M.A.: | (Term expires December 31, 1947). Don F. Cameron, M.D., Fort Wayne. F. S. Crockett, M.D., Lafayette. |
| Alternates: | Norman M. Beatty, M.D., Indianapolis. A. M. Mitchell, M.D., Terre Haute. |
| Delegate to A.M.A.: | (Term expires December 31, 1946). A. S. Giordano, South Bend, elected to fill unexpired term of George R. Dillinger, who resigned. |
| Alternate: | George Collett, Crawfordsville, elected as alternate to A. S. Giordano. |

Place of Meeting for 1946: Fort Wayne.

### ELECTION OF COUNCILORS

Second District—James H. Crowder, Sullivan
Fifth District—A. M. Mitchell, Terre Haute
Eighth District—(Will report later)
Eleventh District—C. S. Black, Warren

(Ninth District reported that Dr. Wemple Dodds, of Crawfordsville, had been appointed to fill the unexpired term of Dr. Romberger, until this appointment can be confirmed at the next district meeting.)

## REPORTS OF REFERENCE COMMITTEES

### SECTIONS AND SECTION WORK

House of Delegates,
Indiana State Medical Association.

Gentlemen:

In consideration of the unusual demands on the time of the individual physicians as a result of the war and the immediate postwar period, as well as the brief time remaining for the work of the Committees, Dr. Overshiner and Dr. Culbertson on Scientific Work and Scientific Exhibits, these committees, more than ever before, have earned the gratitude and thanks of this association for their efforts.

We wish to recommend and thank them.

A. T. Jones, M.D., *Chairman*,
C. P. Fox, M.D.,
G. S. Fessler, M.D.,
I. M. Sanders, M.D.,
Carl Clark, M.D.

(Motion made, seconded, and carried for adoption of this report.)

### RULES AND ORDER OF BUSINESS

Nothing was referred to this Committee; consequently it had no report to make.

### MEDICAL EDUCATION AND HOSPITALS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Reference Committee on Medical Education and Hospitals recommends the adoption of the report of the Committee on Medical Education and Hospitals, page 61, in the *Handbook*. We move the acceptance of this portion of the reference committee's report.

(Motion seconded by Dr. Ross, and carried.)

Because of the desire of many general practitioners to have tangible evidence of their proficiency comparable to that granted by the specialty boards, and because such tangible evidence should act as a real incentive to read and progress with the advances of medicine, it has been suggested that a certificate of proficiency be granted to those general practitioners who have demonstrated their ability and willingness to keep abreast of the advances in medical science.

This should tend to increase the dignity and prestige of the family doctor, and stop the drift away from family practice, a field that has and should continue to include the best minds in medicine. Such a certificate would be evidence of his ability and training, and would make him more

highly respected by his patients and the general public.

Be it therefore resolved that a board of certification for the general practice of medicine be formed.

Be it further resolved that the president of the Indiana State Medical Association appoint a committee, consisting of fifteen members geographically distributed over the state and including at least one representative of the Indiana University School of Medicine to establish such a board.

We move the adoption of this part of the report.

MARLOW W. MANION, M.D., *Chairman*,
HAROLD D. CAYLOR, M.D.,
C. M. SENNETT, M.D.,
V. EARLE WISEMAN, M.D.,
PAUL A. GARBER, M.D.

(Motion carried for adoption of this report.)

### PUBLIC POLICY AND LEGISLATION

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your Reference Committee on Public Policy and Legislation wishes to commend all of the committees whose reports were referred to it for their excellent work during the past year.

1. We recommend the approval of the report of the Committee on Public Policy and Legislation as printed in the April issue of the Indiana State Medical JOURNAL.

2. We recommend the adoption of the report of the Council on Medical Service and Public Relations as printed in your *Handbook* on page 59.

3. We recommend the adoption of the report of the Advisory Committee to the Bureau of Maternal and Child Health of the Indiana State Board of Health as printed in your *Handbook* on page 76.

4. The Liaison Committee of the Division of Services for Crippled Children had no report to make, and there is no recommendation.

5. The Physical Therapy Committee made no report, and there is no recommendation.

6. The report of the Medical Relief Committee is approved as printed on page 109 of your *Handbook*.

7. The report of the Committee on Rural Medical Care is approved as printed in your *Handbook*, on page 72.

(Motion carried for adoption of this section of this report.)

8. The report of the Committee for the Study of Lay Activity in Medical Practice is approved as printed in your *Handbook* with this suggested change—paragraph 4, page 68; paragraph 4 to read,

"That the minutes of each meeting of the State Executive Committee be read, as published in THE JOURNAL of the Indiana State Medical Association, to the members of each county society at the next stated meeting of the society after such publication."

(Motion carried for adoption of this section of the report.)

9. The resolution presented from the floor by Dr. M. C. Topping, chairman of the Committee on Civic and Industrial Relations, is approved. It is also recommended that a copy of this resolution be sent to the Governor of the State, and to members of the Industrial Board. (See minutes of the first meeting of the House of Delegates for copy of this report.)

(Motion carried for adoption of this section.)

10. Your committee approved the resolution presented by Dr. Gatch, to instruct delegates to the A. M. A. convention in December to support the creation of a General Practice Section as a specialty, as proposed by the delegates of the Michigan State Medical Society.

(Motion carried for adoption of this section of report.)

11. Your committee desires to recommend specifically the adoption of section 8, page 41, of the Executive Committee's report. This section reads as follows:

"8. *Annual registration fee.* The Executive Committee recommends to the House of Delegates that the Legislative Committee be authorized to present a bill at the next session of the General Assembly, providing for an annual registration fee, to give the newly-created State Board of Medical Registration and Examination sufficient funds to carry on its duties properly."

H. W. EGGERS, M.D., *Chairman*,
E. VERNON HAHN, M.D.,
F. M. LYNN, M.D.,
C. E. BRISCOE, M.D.,
E. O. NAY, M.D.

(After considerable discussion at this point by Dr. Daniels, Dr. Eggers and Dr. Oliphant, it was moved that this section of the report be amended to specify that the fee be $2.00.)

Dr. Beggs asked what this money was to be used for, and Dr. Beatty made some explanatory remarks.

THE PRESIDENT: It has been moved and seconded that the annual registration fee be set at $2.00, thereby amending the report of this Reference Committee.

DR. ROMBERGER: This matter has been up for discussion in the Executive Committee and Council on numerous occasions, and for fear that there might be lack of full understanding of what you are voting on in this amendment, I would like to make a brief statement of fact in clarification. The action which you take today is instruction to your Legislative Committee to attempt to have this written into the law. It is not that we are assessing ourselves, but it is that this House of Delegates goes on record as instructing their Legislative Committee to incorporate that in the law in the coming

assembly. The law would then have to come before the assembly, be passed, and then become effective.

THE PRESIDENT: The question before the House then is on the amendment to the report of the Reference Committee, to the effect that a $2.00 fee be specified as the amount for annual registration. (Motion carried.)

The question before the House now is on the adoption of the section as amended. (Motion made, seconded, and carried for adoption of this section of the report, as amended.)

(Motion was made, duly seconded, and carried, that the report as a whole be accepted.)

### PUBLICITY

(Nothing having been referred to this Committee, there was no report.)

### HYGIENE AND PUBLIC HEALTH

House of Delegates,
Indiana State Medical Association.

Gentlemen:

*Committee on Physical Fitness*, page 76. It is noted with regret that no report was made by the standing committee on Physical Fitness despite the fact that this is a much-discussed subject in lay publications and radio programs. Your attention is called to THE JOURNAL of March, 1945, relative to this subject. (Motion made, seconded, and carried for adoption of this section of report.)

*Committee on Mental Health*, page 74. Your committee notes with pleasure the consideration given to the returning service man. Particular attention was given to provisions of Senate Bill 206, as passed by the last legislature, providing for a state Council on Mental Health. It is noted, with great pleasure, the fact that the committee, under the chairmanship of Dr. Larue Carter, has begun the spade-work for the building of the new psychiatric hospital in association with the Indiana University School of Medicine. Your committee wishes to warmly commend this committee for its work, and urges that it continue with all expedition. (Motion carried to adopt this section of the report.)

*Committee on Venereal Disease*, page 88. Your reference committee wishes to commend the report for its stand—

1. On the management of the syphilitic in industry, and the safeguarding of rights therein.

2. For its word of caution in the interpretation of the biologic false positive serological reactions. (Motion carried for adoption of this section.)

*Committee on Control of Cancer*, page 85. We wish to quote the paragraph of the report in the *Handbook* in reference to the establishment of detection clinics, top of page 86: "There is an effort to have these clinics largely a matter of detection, and they are open to all for diagnosis. Treatment in these clinics is limited to those unable to pay. These detection clinics are insofar as possible staffed by a clinician and a laboratory man."

It is the sense of your reference committee that the first sentence quoted, "that they are open to all for diagnosis" needs clarification as to just what patients may be accepted for study. As it stands, anyone, regardless of economic status, may apply for diagnosis of cancer. It is our opinion that this is contrary to our established ideas of the practice of medicine and that it violates the doctor-patient relationship. We believe this is a matter that should be placed before the House of Delegates.

On the other hand, the committee is to be commended for the establishment of fellowships for study and research in cancer, and the establishment of the "cancer cupboard" for supplying of dressings, etc., for the indigent cancer patient.

(Dr. Ritchey moved the adoption of this report; Dr. Daniels seconded the motion.)

DR. BEATTY: I move that the report be amended to read that the Association approve the use of diagnostic clinics for cancer, but that these clinics be restricted to the use of indigents. (Motion duly seconded.)

DR. GIORDANO: I wish to concur with the reference committee in their statement that the committee report is ambiguous. It is unfortunate that the A. M. A., has not taken a definite position in defining the policy by which the so-called "Cancer Clinics" are organized. I do not know who wrote the committee report, but as a member of the committee I was never invited to any meeting, if such a meeting was ever held. By letter, I protested to the chairman of the committee, particularly on that portion of the report that deals with the personnel of the Cancer Clinics. As a member of the state committee of the American Cancer Society, I may state that this society will be guided entirely by the wishes of organized medicine in the organization and control of Cancer Clinics. Therefore, it is up to us to decide upon a definite policy, at least as far as the State of Indiana is concerned. In some states there have been organized so-called "detection clinics" which entirely by-pass the general practitioner. I feel that this is a wrong principle. On the contrary, every general practitioner should be a detection clinic. The question of whether or not an individual may or may not have cancer is frequently a very difficult problem, and medicine should make that very clear to the general public. In view of the fact that the general public has taken a very keen interest in cancer, it behooves us not to be too hasty in formulating a policy that deals with Cancer Clinics. I suggest that the president appoint a special committee to study this matter and report to the house at the next meeting.

DR. JONES: We have one of these clinics in Madison County, and I am at present chief of this clinic, and the national organization for control of cancer is pretty well out of our control. I think what Dr. Giordano just said is very true. Aside from the national policies of this organization we are having considerable difficulty with our local group, who do not follow the policies of the national group, and we have quite a bit of trouble to organ-

ize such a clinic satisfactorily, both to the lay group and to our medical group. I think our clinic is about to fall through for lack of interest of the medical men, and I think there should be great care in our contact with this national cancer group, in our approach to them as to what they want to do.

THE PRESIDENT: Dr. Ritchey wishes to discuss this as an individual delegate.

DR. RITCHEY: One of the objections to this is, insofar as possible, that it will be staffed by a clinician and a laboratory man. It leaves the inference that about all you need to do is to look at somebody and detect cancer. If you get into the diagnostic study of this thing, you all know that takes a large amount of equipment and a pretty big team with good teamwork. Detection of cancer at the time when it is useful, and the education of the layman about that, is a big problem, and I don't believe this, as written up, answers that question.

THE PRESIDENT: Is there any further discussion? It has been suggested that this matter might be referred to a committee for study, and that this committee would report back at the next meeting of the Council. Is there a motion? (Motion made by Dr. Caylor, seconded, and carried.)

(Dr. Ritchey moved for the adoption of this report as amended; seconded by Dr. Daniels, and carried.)

*Committee on Industrial Health*, page 93. The subject matter in this report denotes a great deal of activity on the part of the committee. It is hoped that industrial postgraduate courses curtailed to some extent during the war may be resumed.

A code, amplifying ethics, page 94, between industrial and private physicians, has been recommended again. We wish to call particular attention to item 6 of the code, providing for review of medical testimony by the Council. Your reference committee moves the adoption of this report. (Motion carried for adoption.)

Your reference committee, in compliance with the report, recommends the drafting and attempt to have enacted by the State Assembly a waiver law. (Motion made, seconded, and carried, to adopt this section of the report.)

*Anti-Tuberculosis Committee*, page 99. Your reference committee recommends the adoption of this report. (Motion carried for adoption.)

*Committee on Conservation of Vision*, page 102. Your reference committee recommends the adoption of this report as printed in the *Handbook*. (Motion carried for adoption.)

*Committee on Hard of Hearing*, page 103. Your reference committee recommends the adoption of this report. (Motion carried.)

*OPA Medical Advisory Committee*, page 153. Your reference committee not only moves the adoption of the report as printed in the *Handbook*, page 153, but also wishes to commend the members, Drs. C. L. Rudesill, R. A. Solomon, and William Dugan, for their very fine services in the touchy and often thankless task. (Motion for adoption of this section of report carried.)

(Motion for adoption of the report as a whole, as amended, carried.)

J. O. RITCHEY, M.D., *Chairman*,
R. J. HARVEY, M.D.,
CLAY A. BALL, M.D.,
C. M. DONAHUE, M.D.,
E. R. CLARKE, M.D.

### AMENDMENTS TO THE CONSTITUTION AND BY-LAWS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Reference Committee on Amendments to the Constitution and By-Laws recommends the adoption of the amendments to Chapter VII of the By-Laws concerning meetings of the Council, introduced by Doctor Sparks. (See minutes of first meeting for copy of amendment.)

J. H. WEINSTEIN, M.D., *Chairman*,
M. B. CATLETT, M.D.,
MAX ADAMS, M.D.,
C. E. CANADAY, M.D.,
J. T. CARNEY, M.D.

(Motion made, duly seconded, and carried for adoption of this report.)

### PUBLICITY

DR. GORDON THOMAS: I am now able to report on the Reference Committee on Publicity.

We recommend that the Report of the Bureau of Publicity, as printed in the *Handbook*, on page 51, be accepted, with this clarifying statement in section (2) concerning the policy of news releases in emergencies:

All news releases are to go through the Bureau. In the case of an emergency, they are to clear through the office of the Executive Secretary.

I move that this report be adopted.

GORDON A. THOMAS, M.D., *Chairman*,
J. H. BARROW, M.D.,
JOHN R. FRANK, M.D.,
L. R. MILLER, M.D.,
RALPH W. LOCHRY, M.D.

(Motion seconded, and carried.)

### REPORTS OF OFFICERS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Reference Committee on Reports of Officers wishes to commend the President's Address. Its scope is broad, the problems and trends of the coming year are clearly defined, and the approach is realistic.

It is regretted that there could be no similar communication from the President-elect, but cir-

cumstances beyond his control made an address impossible.

The committee recommends the adoption of the Report of the Executive Secretary as given, also the report of the Treasurer.

The Report of the Chairman of the Council, with its additional report, has been considered and its adoption recommended.

The Committee has been impressed with the immense amount of work done by the Council and the Executive Committee, also with its sane approach to the multitude of problems forced upon the medical profession by reconversion.

The Report of THE JOURNAL Publication Committee reveals a record of achievement under great difficulty, of which we should all be very proud. The adoption of these reports is recommended.

G. A. COLLETT, M.D., *Chairman*,
P. Q. ROW, M.D.,
HARRY P. ROSS, M.D.,
F. R. N. CARTER, M.D.,
R. C. BEELER, M.D.

(Motion made, duly seconded, and carried for adoption of report.)

### COMMITTEE ON CREDENTIALS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

We, the Reference Committee on Credentials, accept the report of the standing Committee on Credentials as published in the *Handbook*, page 36, and move that this report be accepted.

A. E. STINSON, M.D., *Chairman*,
ROLLIN MOSER, M.D.,
N. A. JAMES, M.D.,
JON N. KELLY, M.D.,
J. FRANK MAURER, M.D.

(Motion for adoption of this report carried.)

### MISCELLANEOUS BUSINESS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Reference Committee on Miscellaneous Business appreciates the efforts of the Committee on Arrangements, and feels that a vote of thanks is in order for the very splendid meeting which they have made possible. We recommend the adoption of this portion of our report. (Motion carried for adoption.)

The Secretaries' Conference, of January 21, 1945, presented an excellent and instructive program and, as this conference is a very important part of our state society's activities, it certainly should be a "must" each year. We recommend the adoption of their report. (Motion carried for adoption.)

The Committee on Necrology and History is to be commended on its work and the progress that it is making in compiling a medical history. We hope the good work will be continued. We recommend the adoption of their report as printed in the *Handbook*. (Motion carried for adoption.)

The Committee on Indiana Inter-Professional Health Council has been of great service in aiding health conditions in our state. We commend their work, and move the adoption of their report as printed in the *Handbook*. (Motion carried for adoption.)

The report of Doctor Bird and his committee, as presented in the *Handbook*, is comprehensive, and we trust that with the cessation of hostilities their work will be less arduous. They have done a splendid job, and we are greatly indebted to them. We move the adoption of their report as printed in the *Handbook*. (Motion carried for adoption.)

DR. LOHMAN: Dr. Bird presented to me a supplemental report yesterday morning. This has not been read to the House of Delegates, and I am at a loss as to how to handle it.

(A short discussion resulted in the decision that it be read to the House.)

DR. LOHMAN: This is the supplemental report of the War Participation Committee:

"To the House of Delegates:

"1. The annual report submitted to the printer on July 19, because of world events is now obsolete. Two hundred seventy-five doctors have been released from service.

"2. There are more than forty stringent areas in Indiana in need of doctors, and this number will tend to increase, because, the threat of induction past, the 4-F men who were allocated already have moved elsewhere, and many of the doctors returning from service are not going back to their old locations in small towns. The younger men, imbued with the idea of specialism, expect to qualify for one of the specialty boards, and then locate in centers of population. This condition will continue to obtain until bread-and-butter necessity overtakes them. Thus, is presented a problem demanding solution, which, if not met, will be met for us by agencies not friendly to present-day medicine. One suggestion is to allocate a resident from internship for one year, giving credit, setting up a rotating service.

"3. The Committee on Postwar Medical Service has confronting it the question of assistance to doctors released from service. The problems of the returning doctor are many and varied. In civilian life a doctor gives orders. In military service he takes orders. In civilian life he recognizes no superior. In military service he is subordinate to his superior officer. He made a tremendous adjustment to military routine; now he must readjust to civilian life. Many are confused and apprehensive. There are those who need financial help. There is an undercurrent of dissatisfaction, so great that there is a threat to organize a new national medical association, and sixty thousand represents a potentiality not to be ignored. War in itself, that is,

the very fact of war, is disturbing and calculated to beget bizarre reactions. This is enhanced by intimate contact with combat contingencies. Most complaints received have not been passed on to the profession. However, the members of this body received a modified multigraph of a letter wherein the doctor commits to writing sentiments which exemplify the undercurrent of unrest among service doctors. Much more can be read into this letter than the mere question of housing. The conditions, then, that confront the profession as part of a postwar reconversion program can not be dismissed by complacency. They can not be ignored and charged up to resentment, psychological disturbance, or an escape mechanism.

The following telegram was sent to this doctor:

'Am submitting your case to the state association next Tuesday: wire collect name of doctor usurping office space, what representations have been made to him, to the .... County Medical Society, or the ..... County P&AS.'

"The Reply:

'Doctor ..... usurping former office space. Refused direct request to vacate. Feel ..... County Medical Group would afford no help.

(Signed) ....., M.D.'

"In this instance the responsibility primarily is one of the ..... County Medical Society. Therefore, I have asked Dr. ..... , P&AS chairman to come or send a representative to speak for them, *if you desire to hear him.*

"The conditions overt or implied in this undercurrent of dissatisfaction call for militant action, backed by a spirit of charity, tolerance, and helpful cooperation. They can, must, and will be met!

"4. As the sun sets, then, on a heroic six years of activity, and the curtain descends marking the end of the War Participation Committee, attention is invited to the unswerving devotion to duty of the three hundred doctors over the state, composing the county P&AS groups: to the unstinted support of the state association: to the cooperation of Selective Service, the Army, and the Navy. Indiana set the pace for the nation.

"To the 1272 men and 3 women who responded to the call of their country, may an abiding satisfaction go with them down through the years."

THE PRESIDENT: This supplemental report may receive action by the House upon a motion to suspend the rules for its consideration. (Dr. Topping so moved, seconded by Dr. Oliphant, and motion carried.)

(After some discussion at this point, it was moved by Dr. Lohman that this report be adopted, with the deletion of the personalities or names that were mentioned therein. Motion duly seconded and carried.)

We recommend the adoption of the report submitted by Dr. John D. Van Nuys, chairman of the Committee on Postwar Medical Service, and hope that each county society will do its part in our postwar readjustment period. (Motion carried.)

There was no report of the Medical Economics Committee.

The Committee on Rehabilitation Services had no report to make.

The resolution of Dr. Paul A. Garber relative to a permanent home for the state association is timely, and we recommend the resolution for consideration and possible adoption, and that it be referred to the Council. (Motion carried.)

M. R. LOHMAN, M.D., *Chairman,*
E. B. JEWELL, M.D.,
A. C. YODER, M.D.,
F. B. MOUNTAIN, M.D.,
K. L. HULL, M.D.

(Dr. Lohman moved that the report as a whole, with its supplemental report, be adopted; motion seconded and carried.)

DR. COMBS: I was expecting the report of the Centennial Committee to be referred to this Reference Committee, because I desire certain action, and now it seems it is not coming up.

THE PRESIDENT: It seems that, due to the fact that this matter was originally referred to the Reference Committee on Publicity, and then was changed to the Reference Committee on Miscellaneous Business, apparently without the knowledge of the Chairman of the Committee on Miscellaneous Business, it has had no consideration. Therefore, it may be considered in open meeting here by a suspension of the rules.

(Moved, seconded and carried, that the rules be suspended in order that Dr. Combs' report might be considered in open meeting.)

DR. COMBS: This will just take a minute. The report is routine and I am sure it is acceptable, except that we asked for the publication of a Memorial Volume, and this will entail a slight expense for stenographic work, probably not to exceed $250.00, but we would like to have that approval so that we can go ahead with the publication of the volume.

I move that this report be accepted and that the Committee be empowered to proceed with the preparation of the Memorial Volume. (Motion seconded by Dr. Daniels, and carried.)

DR. BEATTY: You will recall that at the meeting on Tuesday it was announced that yesterday there would be a meeting of those of our members who have been in service, and who are in service, for the purpose of discussing their problems, and to present to this body today any resolutions that might be helpful to the returning serviceman. They have had such a meeting, and we have with us this morning a representative of that group, and I would like to ask the consent, and the suspension of the rules, so that this group might have the opportunity of presenting a resolution which comes from the meeting of these servicemen.

I now move that the rules be suspended for the purpose of introducing to you the representative of this group. (Motion seconded by Dr. Lohman, and carried.) I would like to introduce

to you Dr. Rogers Smith, who attended this meeting and who has a resolution for your consideration.

DR. SMITH:

WHEREAS, The problems of the medical officer returning to civilian practice or the completion of his graduate training at the time of separation from active duty present problems which only organized medicine, as represented by the Indiana State Medical Association and the American Medical Association and their component parts can solve, and

WHEREAS, these problems are acute, requiring prompt action, therefore be it RESOLVED:

1. That, the House of Delegates of the Indiana State Medical Association establish a Servicemen's Section, the membership of which will consist of those men separated from service with the armed forces and registered at French Lick during the 1945 annual meeting and members of the American Medical Association in good standing who return to the State of Indiana and become members of the Indiana State Medical Association.

2. That, the Committee on Post-War Medical Service of the Indiana State Medical Association provide a means of registration for medical officers returning from the armed services, and a special service and information to such registrants through the Executive Office of the Indiana State Medical Association.

3. That, the County Committee of Procurement and Assignment Service in each county be responsible for prompt assistance in procuring adequate office space and residence for physicians returning to former locations from the armed forces.

4. That, the Indiana State Medical Association establish a loan fund from its reserve fund, or similar funds, for the benefit of physicians returning from the armed services.

5. That, the Post-War Medical Service Committee of the Indiana State Medical Association increase the facilities for completion of graduate training, interrupted by service in the armed forces, in institutions in the State of Indiana, recognized by the American Medical Association by means of:

(a) Assistant residencies financed according to provisions of the GI Bill of Rights and not increasing the budget of such institutions.

(b) Supplement the residencies above by a schedule of assistancies in the offices of qualified physicians.

(c) A plan to provide housing and adequate shelter for the families of physicians participating in such training.

6. That, a resolution be made to the Board of Trustees of the American Medical Association for civilian consultants to the medical services of the Army, the Navy, and the Veterans Administration for the purpose of providing maximum and efficient medical care to members of the armed forces at the time of war, and to utilize the skill of medical officers to the greatest advantage by assignments according to the special training of such officers and distribution of medical officers in a manner to avoid the loss of such skill in replacement depots and officer pools.

COMMITTEE ON RESOLUTIONS

C. F. THOMPSON, M.D., *Chairman*,
E. ROGERS SMITH, M.D.
JAMES GOSMAN, M.D.
RUSSELL MALCOLM, M.D.
MAURICE GLOCK, M.D.

THE PRESIDENT: What is your pleasure in regard to this report?

(Dr. Catlett moved the report be accepted; seconded by Dr. Oliphant.)

DR. BEATTY: I would like to amend the motion, to state that the details for working out such a program be referred to the Council.

THE PRESIDENT: The question is now on the adoption of the resolution as embodied in the report, as amended. (Motion carried.)

The next order of business is formal resolutions of appreciation.

DR. OLIPHANT: I would like to clarify the election of councilors at this meeting, who are to serve out unexpired terms in the districts where the councilor has not been elected. We have run into some difficulty in the past, in the state association, and I wish to have some kind of a clarifying statement that these councilors so elected are to serve until the regular councilor districts meet and elect their councilmen.

THE PRESIDENT: I think that is a matter that calls for information. I think, where a councilor has been elected by the delegates to complete an unexpired term, it is more or less understood that he will complete that term, and the office will then be open for action by the delegates or the members of the district which is concerned.

DR. OLIPHANT: But he shall serve until such time as that meeting is held and a regular councilor elected?

THE PRESIDENT: That is my interpretation. Is there any objection to that interpretation? Hearing none, the chair will consider it as the wish of the House.

DR. SPARKS: Regarding the invitation to Fort Wayne, I just had a conference with the "Three Wise Men," and they mention the possibility of inadequate housing. We talked about that at the time we considered inviting the association, and when we get back we will immediately get in touch with the hotel men, and if it is impossible to arrange for adequate hotel facilities the invitation must necessarily be contingent upon that fact. We will bring back the information immediately and report back to the Council at the earliest opportunity.

THE PRESIDENT: That isn't to be interpreted as a withdrawal of your invitation?

DR. SPARKS: Not at all.

THE PRESIDENT: The chair will entertain motions.

Dr. Scamahorn: I would like to offer a resolution commending our president, Dr. N. K. Forster, for his excellent work during the year of 1945. (Seconded by Dr. Combs.)

Dr. Ferrell: It has been moved and seconded that we offer a resolution commending the work of our president, Dr. Forster, for his excellent work during the year of 1945. All those favoring such a resolution, make it known by saying "Aye." (Motion carried.) (Applause.)

The President: Gentlemen, I am, indeed, very grateful for this kind expression of your confidence. Thank you very much.

Are there any further resolutions?

Dr. Barclay: I move that the Indiana Press and the various Press Services be recognized, commended, and the gratitude of this House of Delegates be expressed for their capable reporting of the various activities of this meeting of the Indiana State Medical Association. (Seconded by Dr. Lohman; carried.)

Dr. Daniels: I wish to move that we express our very great pleasure in the local management here, of the societies of this district, and the several who were key ones in entertaining this society at French Lick this session. (Motion duly seconded, and carried.)

Dr. Black: I would like to yield the floor to Dr. Hahn.

Dr. Hahn: In the early part of this meeting I asked for a reconsideration or an addition to the action already taken by the House of Delegates on this insurance matter. There is still a considerable body who would like to have an addition to the action already taken.

I therefore move that the Council be instructed in carrying out the directive adopted on November 6, to report whatever plan it approves and recommends, on prepayment of medical care, to a special meeting of the House of Delegates before any final action is taken.

(Seconded by Dr. Duemling.)

The President: The question before the House then is that the Council be instructed to report whatever plan for prepayment of medical insurance it may adopt to a special session of the House of Delegates for approval, before any final action is taken thereto. Is there any discussion?

Dr. Fox: We adopted a plan, didn't we?

The President: Only to the effect that this plan will be of the indemnity type.

Dr. Sparks: We have had three committees for three successive years, as well as the last special committee, to study this thing and report back to the House. Every one of them reached the same conclusion. If the action as moved by Dr. Hahn is taken, the Council will again be put in the position of another committee, and I think we will simply postpone the action that we have been discussing for three years, and will be no further along. It is important that we get some action now. Therefore I move that that motion be tabled. (Motion seconded.)

The President: There is no discussion. This question of tabling a motion is not debatable and will be put before the House. As many as are in favor of tabling this motion will please rise. (Mr. Hendricks counted; result 34.)

As many as are opposed to the tabling of this will arise. (Mr. Hendricks counted; result 39.) Therefore the motion to lay it on the table is lost.

The question then reverts to the original motion of Dr. Hahn regarding the instructions to the Council. Is there any discussion?

Dr. Stocking: Gentlemen of the House, as Dr. Sparks has said, this proposition has been returned to the House of Delegates twice already. Now, sooner or later, if this project is to be carried out, it must be turned over to a relatively small group of our society to be implemented. Those of us who went through the putting into action of the Blue Cross Plan can readily realize the tremendous amount of detail involved, which cannot possibly be approved in its every single detail by such a large group as the House of Delegates. All of the information available has already been worked over twice by competent committees. I think that we can very easily trust our Council to handle this matter from here on in. They have already been instructed that the plan must be an indemnity plan. I do not feel that it is just to them to insist on further limitations of the method which they may choose. Those methods are influenced considerably by the nature of the insurance laws of the State of Indiana, and those matters are most efficiently and effectively considered by a group such as the Council, or a smaller group they might possibly appoint. As far as the desirability of these plans is concerned, I do not think there is any further question about that. They have been approved by the A. M. A.; they have been recommended by the Council on Public Relations of the A. M. A.; and they have been recommended by the National Physicians Committee. I do not feel that any further delay is desirable in any way.

Dr. Atkins (Rush County): I agree that a small group has already handled this insurance business. It is a strange demonstration of democracy that this House of Delegates should adjourn and the Council consider one of the most far-reaching matters of legislation without any opportunity for the House of Delegates to express themselves whether they do or do not want this insurance plan.

Dr. Beggs: I feel that there are quite a few doctors in the State of Indiana who are very much afraid of a mutual plan. I was instructed to vote for a stock company, and I am sure many other delegates were. I think it should be up to this body to make the final decision on the type of plan we will have. I am sure that there are sincere advocates for each plan, and there are sincere advocates who fear a mutual plan because they fear some labor organization might take the company away from them.

Dr. Black: I, as a member of this Council, am very desirous that this House of Delegates put its final seal of approval upon any plan that we may formulate, which I think should be published in The Journal so everybody could be completely satisfied, with a perfect knowledge of the situation, and then brought before the House of Delegates for their final approval. I for one am not in favor of thirteen men shoving something down these 3,000 or 3,500 members of the Indiana State Medical Association, without the House of Delegates' approval. (Applause.)

Dr. Steele: I have just gotten out of service. About 25 per cent of your total membership has been in service and knows nothing about this insurance thing. I am confused about what has happened here. I believe in an indemnity plan, but I don't think it is fair to us, or to any of the other members, to start a plan without further consideration. We don't know whether we want a stock, mutual, or commercial company, or one run by the medical society. I think a final plan should be submitted to us before it is put into effect.

Dr. Duemling: I would like to say that it is only fair to the men who are still in the service; if you have waited and fiddled around for four or five years, wait until some of the other boys get back and find out what it is all about. I'm just as confused as he is.

The President: The question before the House is that the Council be instructed to report whatever plan is recommended for prepayment of medical care to a special meeting of the House of Delegates for final approval, before any final action is taken. Is there further discussion?

(Motion was carried.)

Is there further business to come before the House in the way of resolutions? If not, I should like to say these few closing words:

Throughout the past two years you have been very kind to me, and I want to take this opportunity to express my gratitude to the Council, the Executive Committee, the officers, the members of our various committees, the House of Delegates, the headquarters' office staff, to Ray Smith, our assistant executive secretary, and a very special bow to Tom Hendricks for the unlimited kindness and help given me. I have appreciated the honor of serving as your president far more than I can possibly express.

Volumes could be written on appreciation, gratitude, and kindred emotions. Two words express them all—"Thank you!"

A motion to adjourn is in order. (Moved by Dr. Daniels, seconded by Dr. Brubaker, and carried.)

The Council will meet immediately.

(House adjourned at 10:20 A.M.)

## INDIANA STATE MEDICAL ASSOCIATION

### GENERAL MEETING

The General Meeting of the Indiana State Medical Association this year constituted the entire scientific program, no section meetings being held except for the election of officers.

The morning session, held on Wednesday, November seventh, was devoted to a panel discussion on the subject, "The Disabled, the Physician, and Employment," with Dr. C. M. Peterson, secretary of the Council on Industrial Health, American Medical Association, Chicago, as moderator.

Dr. E. H. Hare, chief medical officer of the Veterans Administration Facility, Indianapolis, spoke on what is happening to the veterans.

Dr. J. R. Crawley, director of Vocational Rehabilitation, Indianapolis, presented an outline of what his bureau is doing to help make self-supporting those individuals who for various physical reasons have been incapacitated.

Dr. Harold A. Vonachen, medical director of the Caterpillar Tractor Company, Peoria, Illinois, spoke on placing the handicapped in industry; the Peoria Plan; and management's viewpoint on utilizing the handicapped.

Dr. Creighton Barker, executive secretary of the Connecticut State Medical Society, New Haven, spoke of the part to be played by medical societies in rehabilitation programs.

Dr. E. S. Jones, chairman of the Committee on Industrial Health, Indiana State Medical Association, discussed community organization for rehabilitation.

The afternoon session convened at two thirty o'clock, with Dr. Jesse E. Ferrell, president-elect, presiding.

Dr. John Ralston Lindsay, professor of Surgery, University of Chicago, The School of Medicine, Chicago, presented a paper on "Méniére's Syndrome."

Lieutenant Colonel Truman G. Blocker, Jr., M.C., chief of Plastic Surgery Section at the Wakeman General Hospital, Camp Atterbury, Indiana, discussed "Problems of Maxillo-Facial Surgery in World War II." His talk was illustrated with slides. Dr. H. M. Trusler, of Indianapolis, discussed the paper.

Dr. Loring Tiffany Swaim, of Boston, Massachusetts, spoke on the subject of "Arthritis."

The officers elected by the various sections were as follows:

Section on Surgery: Chairman, J. Robert Doty, M.D., Gary; vice-chairman, William N. Wishard, Jr., M.D., Indianapolis; secretary, Harold D. Caylor, M.D., Bluffton.

Section on Medicine: Chairman, Marion R. Shafer, Indianapolis; vice-chairman, William M. Dugan, Indianapolis; secretary, Maurice E. Glock, Fort Wayne.

Section on Ophthalmology and Otolaryngology: Chairman, J. V. Cassady, South Bend; vice-chair-

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# THE JOURNAL
OF THE
# Indiana State Medical Association

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA



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Minot, George R.; Castle, William B.; Stroud, William D.; Eusterman, George B.; Dick, George F.; Amberson, J. Burns (The 1944 Year Book of General Medicine) January xxvi
Morgan, Russell H.; Hilliboe, Herman E. (Mass Radiography of the Chest) June xxxiv

Oberndorf, C. P.; Lorand, Sandor; Brill, A. A.; Bunker, Henry Alden; Lewin, Bertram D. (The Yearbook of Psychoanalysis) November xxxii

Page, Irvine H.; Corcoran, Arthur Curtis (Arterial Hypertension, Its Diagnosis and Treatment) March 108
Painter, Charles F. (The 1944 Year Book of Industrial and Orthopedic Surgery) March 108
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Ricci, James V. (One Hundred Years of Gynaecology 1800-1900) November xxxii
Roheim, Geza (The Eternal Ones of the Dream) December, xlviii

Sachs, Ernest (The Care of the Neurosurgical Patient) September xliii
Shastid, Thomas Hall (My Second Life) June xxxiii
Stern, Rudolph A. (Trauma in Internal Diseases, with Consideration of Experimental Pathology and Medico-legal Aspects) July xxxii
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Stroud, William D.; Eusterman, George B.; Dick, George F.; Amberson, J. Burns; Minot, George R.; Castle, William B. (The 1944 Year Book of General Medicine) January xxvi

Titus, Paul (The Management of Obstetric Difficulties) (Third Edition) August xxxi
Tidy, Sir Letheby (A Synopsis of Medicine) (Eighth Edition) September xliii
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Trumper, Max; Cantarow, Abraham (Lead Poisoning) January xxvi

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Allergy, Essentials of Clinical (Taub), The Williams & Wilkins Co. November xxxii
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Childbirth, Control of Pain in (Lull), J. B. Lippincott Co. January xxvi
Constitutional Pathology, Constitution and Disease, Applied (Second Edition) (Bauer), Grune & Stratton, Inc. July xxxii

Digestive Tract, Clinical Roentgenology of the (Second Edition) (Feldman) (r), The Williams & Wilkins Co. July xxxii and August xxxi
Doctors at War (Fishbein) (r), E. P. Dutton & Co. June xxxiv and July xxxii

Eternal Ones of the Dream, The (Róheim), International Universities Press December xlviii

Gynaecology, One Hundred Years of, 1800-1900 (Ricci), The Blakiston Co. November xxxii

Hayfever Plants (Wodehouse), The Chronica Botanica Co. & G. E. Stechert & Co. August xxxi
Hypertension, Arterial, Its Diagnosis and Treatment (Page-Corcoran), The Year Book Publishers, Inc. March 108
Handbook, Interns (Dooley-Holmes), J. B. Lippincott Co. January xxvi

Industrial and Orthopedic Surgery, The 1944 Year Book of (Painter), The Year Book Publishers, Inc. March 108

Interns Handbook (Dooley-Holmes), J. B. Lippincott Co. ____January xxvi

Labor, The Puerperium and the Newborn, A Textbook on Pathology of (McCormick) (r), C. V. Mosby Co. ____January xxvi
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Psychiatry, Fundamentals of (Strecker) (r), J. B. Lippincott Co.____June xxxiv
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Psychoanalytic Study of the Child, The (Editorial Board of the International Universities Press)____November xxxii

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Red Cross First Aid Text Book, American (American Red Cross) (r), The Blakiston Co.____December xlviii
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Roentgenology of the Digestive Tract, Clinical (Second Edition) (Feldman) (r), The Williams & Wilkins Co. ____July xxxii and August xxxi

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Technician, Technical Methods for the (Brown) (r), B-B Printing Co.____November xxxii
Trauma in Internal Diseases, With Consideration of Experimental Pathology and Medico-legal Aspects (Stern), Grune & Stratton, Inc.____July xxxii

Year Book of General Medicine, The 1944 (Dick-Amberson-Minot-Castle-Stroud-Eusterman), The Year Book Publishing Co.____January xxvi
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## ABSTRACT

### PENICILLIN MAY HOLD SEVEN-DAY CURE FOR SCARLET FEVER

The successful seven-day treatment of scarlet fever patients, by the injection of 10,000 units of penicillin into the muscles every three hours, is reported in *The Journal of the American Medical Association* of November 17. The report reveals that this treatment is effective in rapidly eliminating hemolytic streptococci from the nose and throat within forty-eight hours.

Manson Meads, M.D., M. Eugene Flipse, Jr., M.D., Mildred W. Barnes and Maxwell Finland, M.D., with the collaboration of Ruth Drew and Alice Northrop, Boston, studied four groups of nine patients each who were admitted to the South Department of the Boston City Hospital between January and May, 1945, with scarlet fever. Each group was treated differently: Group A without sulfonamides or antibiotics, B with penicillin injections into the muscles, C with sulfadiazine taken by mouth, and D by spraying the nose and throat with penicillin solution.

Summarizing the results with each group, the authors said: "In patients with scarlet fever treated with penicillin intramuscularly, hemolytic streptococci disappear from the nasal and pharyngeal cultures within forty-eight hours, and if the treatment is continued for seven days the original types of streptococci do not reappear.

"Penicillin solution given to similar patients by spraying the nose and throat four to six times a day has very little effect on the hemolytic streptococci in the pharynx, but seems to keep the nose free from these organisms while the treatment is being continued.

"In similar cases sulfadiazine given orally in full doses for seven days results in a suppression in the number of hemolytic streptococci in cultures obtained during the period of treatment only."

Scarlet fever is caused by the streptococcus germ which produces a soluble toxin or poison, which when absorbed into the body is believed to cause the rash of scarlet fever. It usually takes from one to two days from the time of infection to the manifestation of the disease. The disease commences with the symptoms of a severe tonsillitis, but in a day or two a multitude of minute red spots appear on the skin and also on the tongue, tonsils, and throat. In mild cases the temperature begins to drop in five to seven days and the skin rash fades. The skin of the hands and feet peels off in sheets and shreds, that of the body in scales. Scarlet fever is communicated by contact.

The authors further state that the "clinical results also suggest that penicillin given intramuscularly during and for several days after the eruptive stage may minimize or even eliminate the late septic complications (involving ear, heart, and joints and dangerous damage to the kidneys). Furthermore, should these findings be corroborated on a large scale, the present requirement of isolation for scarlet fever patients for three or four weeks would become unnecessary, and patients could be discharged after eight or ten days without danger of giving rise to secondary cases or of cases returning with complications."

The authors emphasize that "these conclusions are based on a very small number of cases and therefore are only tentative. They require corroboration and elaboration in a larger number of cases of various kinds of hemolytic streptococcic infections."

The authors state, "further developments in penicillin therapy may simplify the administration of such a program. Thus the use of penicillin X may result in the reduction in the frequency with which the doses are to be given. It may also be possible to give some of the treatment orally or in lozenges."

(Continued from page 570)

man, Edgar C. Davis, Muncie; secretary, H. C. Wurster, Mishawaka.

Section on Anesthesia: Chairman, John M. Whitehead, M.D., Indianapolis; vice-chairman, Frank W. Ratcliff, M.D., Lafayette; secretary, Roy A. Geider, M.D., Indianapolis.

Section on General Medicine: Chairman, J. T. Oliphant, M.D., Farmersburg; vice-chairman, Claude S. Black, M.D., Warren; secretary, O. E. Wilson, M.D., Elkhart.

In connection with the meeting of the Section on General Practice, Dr. J. T. Oliphant called the meeting to order immediately following the general scientific session. He stated that ninety-six years ago the Indiana State Medical Association was organized by general practitioners, and at last they were being recognized by being permitted to have a Section on General Practice. Dr. W. D. Gatch made a few remarks, stating that he fully endorsed this section and would cooperate in its program. A motion was made by Dr. W. L. Portteus that the chairman appoint a committee on publicity to publicize general practice; it was seconded by Dr. Lavengood and carried unanimously. The chairman stated that he would announce the appointees later. After a general discussion by the members present as to what needed to be accomplished by this section, the meeting was adjourned at 5:10 P.M.

## LOCAL SOCIETY REPORTS

**Cass County Medical Society** members met on Friday, November sixteenth, at the Cass County Hospital, Logansport, for a dinner meeting. The guest speaker was Dr. Carl D. Martz, of Indianapolis, who spoke on "Rehabilitation." Eighteen members were present.

**Dearborn-Ohio County Medical Society** members held a meeting on Thursday, October twenty-fifth, in the Public Library at Aurora. Dr. David A. Boyd, of Indianapolis, spoke on "Psychiatric Problems of Returning Veterans."

**Delaware-Blackford County Medical Society** members met November twentieth at Hotel Roberts, Muncie. A Kodachrome motion picture was shown on "Abdominoperineal Proctosigmoidectomy." Twenty-five members were present.

**Elkhart County Medical Society** members met at Hotel Elkhart, in Elkhart, on November first. The speaker was Mr. Max Olsen, who spoke on "Alcoholics Anonymous." A discussion of prepayment medical insurance followed. Thirty members were present.

**Floyd County Medical Society** members held a meeting at the Frances Cafeteria in New Albany, on November sixteenth. The topic of the evening was the "Proposed Medical Fee Schedule for Floyd County." Seventeen members were present.

**Greene County Medical Society** members met at the Freeman Greene County Hospital, at Linton, on November fifteenth. A round table discussion of current medical problems followed the business meeting. Seven members attended the meeting.

**Howard County Medical Society** members held a meeting on November second at the St. Joseph Memorial Hospital, at Kokomo. Dr. Joseph D. Boughman, of Kokomo, presented a paper on "Recent Advances in Anesthesia." Twenty-one members attended the meeting.

**Indianapolis (Marion County) Medical Society** members met October tenth at the Indianapolis Athletic Club. Speakers included Dr. Carl D. Martz, Dr. William F. Montgomery, and Dr. Charles F. Voyles, all of Indianapolis, and Dr. Helen Beall Barnes, of Greenwood.

**Madison County Medical Society** members met on November nineteenth, at St. John's Hickey Memorial Hospital, at Anderson. The guest speaker was Dr. R. M. Vandivier, of Indianapolis, who discussed "Dyspnea."

**Montgomery County Medical Society** members held a dinner meeting, on October eighteenth, at the Culver Hospital, at Crawfordsville. Dr. Walter S. Priest, of Chicago, presented a paper on "Treatment of Subacute Bacterial Endocarditis." Twenty-two members and guests were present.

**Porter County Medical Society** members met on November twenty-seventh, at the Porter Memorial Hospital, at Valparaiso. Dr. C. O. Almquist, of Gary, discussed "Peptic Ulcer." Fifteen members were present.

**St. Joseph County Medical Society** members held their first fall meeting October ninth at the Indiana Club, South Bend. Guest speaker was Dr. H. H. Rodin, of South Bend, who presented a paper on "Massive Arsenotherapy of Early Syphilis." Forty-five members were present.

A second meeting was held October twenty-fourth, when Dr. Richard L. Varco, of Minneapolis, Minnesota, discussed "Dietary Management of the Substandard Surgical Risk." Fifty members were present at this meeting.

## COUNCILOR DISTRICT MEETING

### ELEVENTH COUNCILOR DISTRICT MEETING

The Eleventh Indiana Councilor District Medical Association members held their seventy-fourth semi-annual meeting, at 2:00 P.M., October 17, 1945, in the Public Library at Delphi.

Following the reports of the Secretary, Councilor, and Necrologist, the following papers were presented: "Inaugural," by Dr. Paul W. Ferry, of Kokomo; "Newer Concepts of Glandular Therapy," by Dr. James H. Hutton, of Chicago; "Cervical Dislocation in General Practice," by Dr. E. B. Jewell, of Logansport; "Office Orthopedics," by Dr. William V. Woods, of Indianapolis.

The Carroll County Medical Society was host for the meeting, which included a tea for the ladies.

The next meeting will be held in Peru in May.

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### THIRTEENTH COUNCILOR DISTRICT MEETING

The Thirteenth District Medical Society, meeting jointly with the St. Joseph County Medical Society, held its annual meeting at the LaSalle Hotel, South Bend, on Wednesday, November 14, 1945. Guest speakers were: Dr. Carl P. Huber, Indianapolis, whose subject was "The Use of Logic in Endocrine Therapy in Gynecology"; Dr. William A. Altemeier, Cincinnati, who spoke on "Penicillin in the Management of Acute Hematogenous Osteomyelitis"; Dr. Geza de Takats, of Chicago, talked on "Surgical Treatment of Hypertension"; and Dr. R. L. Sensenich, of South Bend, whose subject was "Social and Economic Trends in Medicine."

The following officers were elected to serve during 1946:

R. A. Fargher, M.D., Laporte_____President
Ernest Dietl, M.D., South Bend_____Vice-President
O. E. Wilson, M.D., Elkhart__Secretary-Treasurer

The annual meeting date and place for the year 1946 are to be determined by the officers and announced at a later date.

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## *WOMAN'S AUXILIARY to the Indiana State Medical Association*

President—Mrs. F. M. Gastineau, Indianapolis
President-elect—Mrs. S. J. Petronella, East Chicago
Corresponding Secretary—Mrs. C. L. Bock, Indianapolis
Treasurer—Mrs. A. W. Ratcliffe, Evansville
Press and Publicity—Mrs. A. B. Richter, Indianapolis

It seems that an unusually large number of doctors and doctors' wives felt that they needed a few days of rest at French Lick. There was a record attendance at the state meeting. The hotel was filled to capacity, and many were turned away.

The Auxiliary activities opened with a State


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Board meeting on Tuesday afternoon, at which time Mrs. F. M. Gastineau, President, welcomed Wells County, our newest group of members. The chairmen and county presidents gave their reports, and it seems that Fort Wayne is still leading in worth-while activities. The *Hygeia* chairman, Mrs. O. H. Bakemeier, reported 455 subscriptions to our credit as compared with 192 of the previous year.

The women's entertainment during the convention was in the charge of Mrs. J. W. Baxter, Jr., of New Albany, chairman of arrangements. She was assisted by the members of the Floyd County Auxiliary and Mrs. E. P. Buckley, of Jeffersonville. Tuesday night, following the dinner for the women, the entertainment consisted of music provided by a charming group of "teen-age" girls and boys of New Albany. Mr. A. Fielder Myers, supervisor of vocal and instrumental music in the New Albany schools, directed the orchestra, and we greatly appreciated their unusual talent. After the doctors had their own smoker and entertainment the women were invited to join in the horse racing contest, which was run on the screen. How much money exchanged hands we have no idea.

The next morning the annual breakfast and business meeting of the Auxiliary was streamlined—not too long. Mrs. Gastineau gave a brief talk, reporting that there was an increase in regular members of 174, and that we now have 122 associate members. Dr. Creighton Barker, executive secretary of the Connecticut State Medical Association, spoke to the group. He briefly discussed the Wagner-Murray-Dingell Bill, in relation to the Hill Burton Bill. He told us that the intent of Senator Pepper's Bill is to continue maternal and infant care to everyone at a fixed level of payment. It includes the care of infants indefinitely after they are born. There will be no fixed income bracket. This bill is popular because it is not going to cost anyone anything. Money will probably be had from "thin air." It will not be for nothing because things aren't gotten that way. All this is a political racket and is not free. He stated that "people are trying to be secure without working for it."

Dr. Tom Hull, Director of Scientific Exhibits of the American Medical Association, talked about the Health Magazine from the standpoint of a health magazine.

Mrs. Creighton Barker brought a greeting from the Connecticut Woman's Auxiliary to the medical profession—the last state to organize. She was responsible for its organization, and says it took five years to do it.

Closing the breakfast meeting, Mrs. C. O. Richey, Evansville, conducted the memorial services by reading the 121st Psalm, and John, 14th chapter, first to sixth verses. As she read each of the following names, she placed a rose beside a lighted candle:

Mrs. B. M. Edlavitch, of Allen County.
Mrs. A. Goldstone and Mrs. Julius Chenigue, of Lake County.
Mrs. Edwin Knox, of Marion County.
Mrs. J. C. Possolt, and Mrs. C. G. Mackey, of Marshall County.
Mrs. Bernard Ravdin, and Mrs. George Royster, of Vanderburgh County.
Mrs. Robert Price, of Vigo County.

Wednesday afternoon the ladies all enjoyed a lovely bridge party on the balcony. There were some gorgeous prizes. The women accompanied their husbands to the annual banquet, where the Honorable Governor Gates spoke and Dunninger entertained us with his perplexing art.

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THE ANNUAL CLINICAL CONFERENCE
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